HILLSIDE HEALTH CENTER:
Doors Closed, Lessons Learned

A Report of the Long Term Care Coordinating Council

Task Force on Nursing Facility Closures
Lt. Governor Charles J. Fogarty
Chairman

November 2004

DEDICATION

We humbly dedicate this report to the approximately 9,200 Rhode Islanders living in our state's nursing homes and to the hundreds of nursing home staff committed to their care and comfort. We hope this report provides guidance on actions we can take to ensure our residents and their families will not have to endure another "Hillside-type" closure. The report also suggests policies to adopt to further promote quality improvement of nursing home care in our state.

Task Force on Nursing Facility Closures
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INTRODUCTON AND OVERVIEW

On June 15, 2004, the last residents moved out of Hillside Health Center, a long term care facility located at 99 Hillside Avenue in Providence, and Hillside closed for business. When Hillside was forced to close its doors, dozens of frail elders were uprooted and forced to find new nursing homes or other residences. For many, this was the second, or even the third, forced move as they had come to Hillside from other closed nursing homes. Hillside's closure caused heartache and anguish for residents and families and exposed serious management and care issues. Its closure also left many wondering how this could have happened.

Hillside Health Center was located in a beautiful building. Its red brick facade leaves one with a sense of substance and stability. Engraved on polished brass plates surrounding its attractive entrance was its mission and vision statements which promised quality care and dignity to its residents.

HILLSIDE HEALTH CENTER VISION
To provide optimum care that respects the privacy, dignity and comfort of our residents and families.

HILLSIDE HEALTH CENTER MISSION
The mission of Hillside Health Center is to assure its residents and families the finest quality of life possible by providing quality medical, nursing, rehabilitation and support services.

Unfortunately, for many residents and families, these were promises that were never fulfilled.

On June 9, 2004, Lt. Gov. Charles J. Fogarty, Chairman of the state Long Term Care Coordinating Council (LTCCC), announced the formation of the LTCCC Task Force on Nursing Facility Closures to investigate events leading to the closing of Hillside Health Center and whether existing policies were sufficient to give the state advance warning on troubled nursing homes in danger of closure. In creating the Task Force, Lieutenant Governor Fogarty posed three questions: "Did we miss the signs that would have pointed to the problem at Hillside? Did we see the signs and not act soon enough? Do we have the right policies in place to trigger warning bells to allow us to act before it is too late?"

To find out what led to Hillside's closure and to determine if its failure could have been prevented, the Task Force conducted a comprehensive review of Hillside's history. The review took a systems-based approach that went back to1994 when the owner originally applied to the state Health Services Council (HSC) to purchase the property and nursing home owned by the Jewish Home for the Aged. The Task Force examined issues relating to

Hillside's financing and considered the state and federal governments' roles in the oversight of Hillside. It held six fact-finding meetings and heard from more than a dozen persons involved with various aspects of the system. It also held a special public meeting to get input from family members and former staff. Task Force staff interviewed other key persons and conducted research to gain additional knowledge and obtain insight into the complexities involved in nursing home operations. Task Force members also reviewed copies of a state Office of Health and Human Services report requested by Gov. Donald Carcieri entitled, "***Review of the Department of Health's Response to the Quality of Care at Hillside Health Center".*** A list of Task Force meetings and presenters is found in Appendix A.

The Task Force concludes that Hillside's failure could have been prevented and that its failure resulted from a number of important contributing factors.

The first was a series of ill-advised decisions made by persons with legal responsibilities related to long term care facilities and residents. These decisions occurred at various points in the system and include decisions made by:

- The state Health Services Council that departed from its standard owner equity provisions relating to nursing homes;
- HUD officials who approved mortgage insurance for Hillside based on risky assumptions about nursing home bed needs and an overly optimistic project financial analysis; and
- Department of Health (HEALTH) officials who failed to use available legal tools, including seeking receivership or imposing temporary management to prevent serious resident care issues and Hillside's ultimate financial collapse and closure.

The other critical factor contributing to Hillside's closure was the failure of its owners, operators and managers to properly govern and manage Hillside despite the significant management and owner fees that were being paid. Hillside's management company and/or owner continued to employ an incompetent administrator who could not maintain the nursing home in compliance. Moreover, management continued to operate the nursing home with apparent disregard for resident well-being as its debt mounted to the point where it became financially insolvent. To avoid this outcome, HEALTH would have had to take unprecedented aggressive action which the department failed to do.

An important Task Force charge was to determine whether existing policies are sufficient to avoid another "Hillside". While the Task Force finds that Hillside's failure could have been prevented, it also recognizes that there are valuable lessons about system weaknesses to be learned from the Hillside experience. The Task Force recommends a number of steps to strengthen existing legal tools to trigger earlier action and to promote quality care in our nursing homes. Among these is an early warning system to flag financial problems or pending financial failure; specific requirements for family and physician notification of poor care; greater state scrutiny of poor performing nursing homes that do not meet the strict federal criteria for substandard quality of care; and a program for providing quality improvement monitoring and assistance.

Part 1. SYSTEM REVIEW

1.1. The Role of the Health Services Council

The Health Services Council (HSC) is a 22-member statutorily created body with members appointed by the Governor (8), the Speaker of the House (8), and the Senate (6). By law, it is responsible for:

- Consulting and advising the Health Department regarding license applications for health care facilities;
- Reviewing and making recommendations on health facility rules, regulations, and standards; and
- Consulting and advising HEALTH on the state Health Care Certificate of Need Act (CON) requirements.

In determining need for health services, state law states that "No approval shall be made without an adequate demonstration of need by the applicant at the time and place and under the circumstances proposed, nor shall the approval be made without a determination that a proposal for which need has been demonstrated is also affordable by the people of the state." (RIGL 23-15-4(b) relating to Determination of Need for New Health Care Equipment and New Institutional Health Services) Department of Health (referred to as HEALTH in this report) regulation, R23-17 CON, further defines affordability as "the relative ability of the people of the state to pay for or incur the cost of a proposal, given:

a. Consideration of the condition of the state's economy;
b. Consideration of the statements of authorities and/or parties affected by such proposals;
c. Economic, financial, and/or budgetary constraints of parties affected by such proposals, including cost impact statements submitted by the State Medicaid Agency or State Budget Officer;
d. Other factors deemed relevant by the Health Services Council or the Director.

In the matter of Hillside Health Center, the HSC was responsible for reviewing and making recommendations to the Director of HEALTH on: the purchase of the Jewish Home for the Aged by Hillside; a change in ownership relating to the license (known as a Change in Effective Control or CEC); and a Certificate of Need (CON) for building renovations.

The HSC reviews on Hillside Health Center had a tortuous history. They took place over a period of almost five years, from October 1993 to August 1998, with HEALTH's initial approval of the purchase of the facility from the Jewish Home for the Aged for $5.1 million taking place in April of 1994. A detailed chronology of these activities was prepared by HEALTH staff at the request of the Task Force (see Appendix B.) HEALTH staff noted that during the course of these reviews, there were many changes regarding cost, financing, marketplace situation, nursing home bed need and laws regarding criteria for the CEC and CON.

Noteworthy in the Hillside HSC review process are decisions made by the full HSC which substantially revised recommendations made by a Project Review Committee or that were subsequently modified or rejected by the HEALTH Director. For example, the April 26, 1994

HSC Project Review Committee report on the application of Hillside Health Center Associates, LP's application to purchase the Jewish Home for the Aged of RI showed that the committee, in a 5-0 vote, recommended approval of the application with a condition for 20 percent owner equity. The 20 percent equity provision is a working policy used by the HSC for approving Change in Ownership applications and renovation projects.

> ***Excerpt from Project Review Committee Report, April 26, 1994***
> *"The committee was absolute in its conviction that the most appropriate way to ensure that the reopening of this troubled facility, especially one with potential labor and physical plan difficulties, was for the applicant to abide by the longstanding Health Services Council's policy of a minimum of 20 percent of capital cost in the form of equity (i.e., non-debt) funding. This commitment would serve as a down payment at the time of the sale to ensure that the applicant attain and maintain a significant financial security in the facility. The committee was very concerned about the fact that the purchase and sale agreement did not provide for any substantial "at-risk" long-term investment by the purchaser in the project (beyond the $50,000 deposit – approximately one percent of capital cost) between the buyer and the seller."*

At the full HSC meeting of April 26, 1994, the conditions for approval recommended by the Project Review Committee were modified to an effective one percent equity requirement as follows: *"that the applicant finance the application with a $50,000 deposit, $300,000 to be placed in an escrow account to be used by the applicant for working capital, that $150,000 be in the form of security on the personal residence of Antonio Giordano, and that the remainder be in the form of a promissory note from the buyer to the seller."*

This recommendation passed on a vote of 17-1, with the Chair abstaining. According to the report, during the meeting the applicant's lawyer *"...stated that it would be very difficult for Mr. Giordano to get $1,000,000 cash in today's market, and that if the full Council went along with the PRC report, it would be effectively terminating the project."*

The full HSC recommendation of one percent owner cash equity was subsequently modified by former HEALTH Director, Dr. Barbara DeBuono, to 10 percent in cash equity ($507,000) in the form of an upfront cash payment to be applied to the total purchase price. (April 28, 1994 letter from Dr. Barbara DeBuono to John Montecalvo, CFO, Hillside Health Center Associates, LP). This 10 percent owner equity requirement for the CEC was initially appealed by Hillside but they dropped the appeal at a later date.

In regard to the Certificate of Need (CON) application, Hillside initially filed an application for renovations of $6.2 million of capital costs for a 236-bed project and stated that the equity would be 20 percent in the form of cash. During the review the project was modified to reduce the capital costs to $5,881,000. The applicant had also noted that it planned to convert an annex building on the Hillside property into a 39-bed assisted living facility but that the assisted living component would have a separate mortgage with separate costs.

During the CEC and CON reviews, HEALTH staff sought input from its Division of Facilities Regulation, the Attorney General's Office, the Department of Human Services and DEPCO regarding issues relating to the applicant's background in nursing home operations, project

affordability and need, equity provisions, working capital, home office expense and facility design. As part of the review, the Attorney General raised a number of issues including the proposed equity provisions and need for the project. The Department of Human Services (DHS) found that the project was not affordable for the state. Issues were raised regarding the applicant's history in regard to former HUD dealings and loans with credit unions investigated by DEPCO. A March 6, 2002 Providence Phoenix article cites a letter from Thomas Demery, then HUD's assistant secretary, in which he writes that in 1987 Giordano was accused of making "false representations to HUD with regard to construction costs and payments of subcontractors or misused construction funds" for projects in Westerly, Burrillville, and Coventry. Giordano was suspended from HUD for four years. Although issues were raised regarding the applicant's background during the HSC review of the applicant, HEALTH staff reported to the Task Force that nothing was found on the record to deny granting the license to Hillside.

On July 16, 1996 the full HSC recommended approval of the CEC and the CON as being needed and affordable at a cost of $5.88 million in renovations with a 15 percent owner equity provision. The state budget officer voted against the proposal stating, *"Again, I think we're here to talk about affordability in terms of the Department of Human Services as going on record as saying that the additional costs to the public are substantial and ongoing."* The DHS representative also raised the issue that there was documentation that the state presently had an excess number of nursing home beds.

On July 22, 1996, HEALTH Director, Dr. Patricia Nolan, approved the CEC with a 10 percent equity provision but denied the CON for the renovations. In her decision, Nolan found that the applicant failed to prove that *"its proposal for the renovations requested is needed and affordable"* and found the evidence presented by DHS and the Budget Officer credible. It is important to note that the issue was not the need for the existing beds at the Jewish Home as the CEC had been granted in 1994, but rather the need for and the affordability or the capital expenditures for the renovations.

The CON denial was appealed administratively by the applicant but was upheld. Subsequently, however, the applicant changed the project from a 236-bed nursing home with 39 assisted living units in an Annex building to a multi-use project with 150 nursing home beds, 70 board-and-care/assisted living units and an adult day center for 50 clients. Under this new scheme, the nursing home renovations fell below the $2 million capital requirement established in 1996 as criteria for CON review. As a CON review was no longer necessary, HEALTH signed off on the project with the condition that the 10 percent equity relating to the CEC approval be verified and this verification was provided.

As part of its work, the Task Force heard from the current Chairman of the HSC, Dr. Robert Quigley, who has a 15-year tenure on the HSC and was a member of the HSC during the reviews of the Hillside applications. Dr. Quigley noted that he consistently voted against Hillside's CON as he had major concerns about the need for the beds and their affordability as well as the equity requirements. Dr. Quigley recommended to the Task Force that the equity provisions be strengthened by putting them into state law. He stated that Hillside representatives came into the hearings with many legal and financial experts to justify the project and were successful in persuading HSC members to approve the project. Dr. Quigley said that the HSC did not always have sufficient financial expertise of its own to adequately

evaluate the financials presented by applicant experts brought in by applicants. He also noted that he is concerned about HSC staff reductions over the past several years and that, at present, there is one full-time staff member and one contract person to assist the HSC. Dr. Quigley said he is also concerned about their ability to fulfill all their responsibilities.

Dr. Quigley also expressed concerns that legislative leader appointment have indefinite terms and that meeting attendance by some HSC members was very sporadic. He told the Task Force that in the past he felt there had been political pressure put on some members with regard to attendance at certain meetings at which certain votes were on the agenda. He noted that this was not the case in more recent years or currently.

In his testimony to the Task Force, Dr. Quigley said "*Hillside is like a '9/11,' a wake-up call, in nursing home oversight. It's not as if Rhode Island is approving a store*," he said, *"where if the business goes under, the state need only shut the doors. We have people to protect."*

1.2. Financing Issues

HUD

The Task Force Chairman requested that HUD officials meet with the Task Force to provide information about its role in financing Hillside. Requests were made to both the HUD local field office and the regional office. Local and regional office staff declined to meet with the Task Force. They noted that HUD was prohibited from disclosing certain financial information subject to the Freedom of Information Act (FOIA) and that a decision had been made not to answer questions regarding this project.

In declining to meet with the Task Force, HUD Regional Office Acting Director, Miniard Culpepper, stated in an Oct. 1, 2004 letter to the Chairman *" Since this project is in receivership, which may effect HUD's legal rights and obligations involving the project, it would not be appropriate for a HUD representative to be in attendance."*

Although she would not meet with the Task Force, the local HUD Field Office Director did arrange for the Task Force staff person and a member of the Task Force to meet with her and several members of the local office staff at their office. At this meeting, HUD staff provided general information about the HUD "232" nursing home program and HUD's role in overseeing projects that it finances. The HUD staff also responded to two FOIA requests by the Task Force and provided a number of requested documents relating to Hillside.

As described by local HUD staff, under the HUD mortgage insurance program, an owner applies to a HUD-backed financial entity authorized under HUD to participate in the "232" mortgage insurance program. Under this program, the loans obtained are non-recourse loans. Non-recourse loans rely on real estate to satisfy the debt. Loans are usually for forty (40) years.

In the event a nursing home goes into receivership, the receiver decides who will get paid. If there are not enough dollars to operate and pay the mortgage, the mortgagee can assign the loan to HUD in which case HUD becomes the mortgagee and is assigned to pay claims. HUD pays off the balance of the principal to the lender. However, the property is still "owned" by

the original owner and it is the responsibility of the owner to pay HUD. When HUD becomes the holder of the note, it has three (3) options.

1. It can enter into a work-out agreement with the owner if it appears financially possible,
2. It can foreclose on the real estate by holding a foreclosure sale with the sale proceeds going towards HUD recovery, or
3. It can do a "note sale" via a national auction in which the note is taken over and a new mortgagee takes over and works out arrangements with the owner.

It was noted that the HUD mortgage insurance stops at assignment of the mortgage to HUD and that when a receiver is appointed, HUD has the option to request a federal receiver.

HUD staff reported that "232" projects are the riskiest and in RI several nursing homes with "232" financing have had financial problems. In response to a Task Force FOIA request, HUD staff reported the following activity regarding foreclosures or note sales on HUD "232" projects in RI since 1997: Rose Cottage (foreclosed), Desilets (note sale - still operative), Slater Health Center (note sale - still operative), Coventry Health Center – (note sale - still operative), Waterman Heights (note sale - still operative), Edmund Place (foreclosed), and Briarcliffe Healthcare (note sale - still operative). The Task Force also asked for and received a list of HUD-insured nursing homes and assisted living residences in Rhode Island which showed 36 nursing homes (slightly more than one-third of the state's nursing homes) as being active properties in the HUD program.

The first step in the HUD "232" process is the approval of a "Commitment for Insurance of Advances" (HUD #92432). A copy of this document for the Hillside project dated June 30, 1998 was provided to the Task Force in response to a FOIA request. This is followed by an initial closing in which the mortgage is put on the property and amounts are paid out on a schedule in accordance with the schedule for construction/renovation. Once the project is completed, a final closing takes place. HUD limits the maximum amount of the mortgage for the "232" program to 90 percent of the combined purchase price and cost of the renovations. The 10 percent balance can not be secured debt. The 10 percent owner equity funds are used for initial payments prior to release of the mortgage dollars.

Task Force staff reviewed the documents provided by HUD showing the agreements with the mortgagee for Hillside, Suburban Mortgage Associates of Bethesda, Maryland, and accompanying project analysis for Hillside. Records obtained from HUD show that Suburban Mortgage Associates holds the mortgage on five other Rhode Island nursing homes. An article in Mortgage Daily.com (March 4, 2002) referred to Antonio L. Giordano as the Founder and CEO of Suburban Mortgage Associates, the same mortgage company that holds the mortgage on Hillside. In light of this, the Task Force Chairman made a FOIA request to HUD on Nov. 15, 2004 asking for any and all documents and communications in HUD's possession which show business relationships between Anthony L. Giordano, Hillside Health Center Associates, LP or Hillside Health Center, LLC and Suburban Mortgage Associates Inc. of Bethesda, Maryland. It is unclear to the Task Force whether this is allowable under HUD regulations or other regulations governing the mortgage and banking industry. The Chairman suggested that if these relations are allowed that Congress look into whether they should be in the future.

A question arose as to whether there had been a final closing for Hillside as several persons had indicated to Task Force staff that a final closing had never occurred. This question was raised to local HUD staff in a FOIA request dated Sept. 27, 2004. In response, HUD provided a copy of the mortgage note and stated in its response letter dated Oct. 26, 2004, "The endorsement panel confirms only initial endorsement."

It is important to note that several legal entities were involved with Hillside. HEALTH reported to the Task Force that Hillside Health Center, LLC is a legal entity owned by Antonio L. Giordano (99 percent) and Consultants, Inc. (one percent). Hillside Health Center Associates, LP is a RI legal entity whose general partner (1 percent) is Consultant's Inc. and limited partner is Antonio L. Giordano (99 percent). Consultants, Inc. is a legal entity which is 100 percent owned by Antonio L. Giordano.

The initial "Commitment for Insurance of Advances" for Hillside showed a single aggregate mortgage in the amount of $12,979,300 to be paid over 40 years at a rate of 7.18 percent with monthly payments of $82,359.92 with the first payment of principal due on the first day of the 12th month following the month in which the mortgage is dated.

Documents filed with the City of Providence Deeds Office were also obtained by Task Force staff. They include a HUD Regulatory Agreement (HUD-92466-NHL) dated Aug. 19, 1998 approving Hillside Health Center, LLC as the lessee of the property and Hillside Health Center Associates, LP as the lessor. Another regulatory agreement in the deed records (HUD-92466), signed the same date, shows Hillside Health Center Associates, LP as the property owner (mortgagor) with a mortgage note of $12,979,300.

The project analysis and appraisal for Hillside submitted to HUD showed a 235-unit multi-use project that included 150 nursing home beds, 35 assisted living units, 50 board and care units and a 50-client adult day care. Total estimated income at full occupancy was $9,960,976 of which $2,620,104 (26%) was from the non-nursing home components. Of the nursing home beds, the payer mix was projected as follows:

Medicaid – 105 (70%)
Medicare – 4 (3%)
Private – 41 – (27%)

It is HUD's responsibility to make sure a nursing home license remains in effect during the period of the loan. HUD looks to HEALTH to see if there are any issues relating to quality of care and HUD staff reported they look at survey results available on-line but do not routinely receive them from HEALTH. It was suggested that if HUD received the survey reports that showed issues of poor care that HUD could trigger a letter to an operator. In terms of monitoring the financial status of its insured facilities, HUD staff reported the following:

1. HUD is notified of late payments on a mortgage from the mortgagee.
2. HUD is notified and must approve requests for loans from a "Replacement and Reserve" Account (an account established to repair and replace real estate assets). Deposits are made into this reserve account every month and it is held under the joint control of the mortgagee and HUD. The mortgagor can request a loan from this account.
3. HUD reviews press reports that provide information on nursing homes.

4. HUD conducts an annual physical assessment of facilities to check on the physical plant.
5. Audited financial statements must be submitted annually. For non-leased nursing homes these are submitted electronically to HUD's national Real Estate Assessment Center (REAC) and a financial performance review using certain required measures is conducted. However, the audited financial statements for leased nursing homes are submitted to the local office in paper form for review.

Local HUD staff is responsible for approving the mortgage insurance applications. In discussing how HUD determines need for a nursing home, a HUD staff person stated that if a license for a nursing home has been issued, they assume that this means a determination of need has been made. In general, HUD can either have the applicant submit a market study or have a separate HUD division conduct a market analysis.

Included in the document package provided to the Task Force by HEALTH was a copy of a market analysis on the Hillside application done for the HUD local Providence office by the HUD Office of Economic and Market Analysis (EMAS) office in Boston. (Memo dated March 25, 1998 from Wendy Lucas, Regional Economist, to Joseph Crisafulli, Dir. RI Multifamily Program). This document questioned the need for the nursing home beds at the time.

> **"However, EMAS found no evidence that there is a need for 150 new nursing home beds in Providence. In fact, there was ample evidence of market trends that suggest assisted living facilities are capturing greater nursing home market share of existing or potential nursing home patients and that these trends will continue into the future….The result of these trends is that occupancies have declined for the last one to five years. Most importantly, occupancies of HUD-insured properties --including two owned by the sponsor—are now in the 80 percent range, down from virtually 100 percent in 1993."**

HUD local office staff indicated that this document was an internal working document which had been revised. Pursuant to a FOIA request, the Task Force received a copy of a subsequent memo from the EMAS Boston office, dated April 21, 1998, which stated that Hillside had submitted a revised proposal on April 6, 1998. This revision targeted as new clients for the nursing home a population of young adults aged 21-59 suffering from chronic diseases such as Multiple Sclerosis, stroke, diabetes, heart and kidney disease, and emphysema that was not part of the original mix of the target market. The memo noted that there were relatively few housing options for these populations and it was possible Hillside could capture some of this demand. The applicant had also noted that the active adult living units would be offered to residents with early Alzheimer's disease and the EMAS memo noted it was possible Hillside could capture some of this demand. Although the April 6th EMAS Memo still found **little to no demand for traditional nursing home beds**, it recommended approval of the project based on the new demand identified.

State Financing and Financial Oversight

John Young, DHS Associate Director for Health Care Purchasing and Quality, reported to the Task Force on DHS' role in financing nursing homes. DHS is essentially a payer for services.

Under regulation, DHS also works with HEALTH and the long term care ombudsman program to relocate nursing home residents in the case of facility closures.

Nursing homes are reimbursed according to Principles of Reimbursement (POR) as detailed in state law and regulation. Currently, the POR are in the second year of a planned three-year phased-in change in reimbursement per Budget Article 41 of the FY2004 budget. DHS establishes provider participation standards using state licensure as detailed in RIGL 23-17 as the base. DHS cooperates with HEALTH and the Attorney General's Office in administering the Medicaid program as it relates to nursing homes and works through the Health Services Council to assess the affordability of institutional proposals. As noted above, in the case of the Hillside CON, DHS found that the proposal was not affordable in that projected costs would have been substantially higher than the Medicaid weighted average daily payment and, in an environment of bed surplus, the effect of adding residents back at Hillside would have resulted in higher effective Medicaid rates for the surrounding nursing homes.

DHS sets individual nursing home Medicaid rates, within the confines of the POR cost ceilings and market arrays, based on cost reports (Form BM-64) submitted annually to the rate-setting unit. In Rhode Island, about 80 percent of nursing home residents are paid for by Medicaid and these payments account for two-thirds of nursing home revenues. In FY2004, Medicaid payments to nursing homes totaled $286,877,088 (state and federal funds). This is 20 percent of all state Medicaid spending. The cost reports are prepared by CPA's engaged by the nursing homes and are subject to field review and audit by DHS. **DHS's John Young reported there is no review of financial status, stability or solvency as part of the process.**

Originally, Hillside was licensed for 150 beds. However, its licensed capacity had increased to 165 beds as of 2001 using a provision in state law that allows a nursing home to increase its licensed number of beds by 10 percent (RIGL 23-17-44). DHS reported the following data on occupancy and payments to Hillside (May, 1999 to 2004)

Period	Total Occupancy	Percentage of Occupancy			Total Medicaid Payments
		Medicaid	Medicare	Private	
5-12/99		64%	18%	15%	$620,000
2000	92.6%	75%	10%	11%	$3,854,960
2001	91.5%	77%	7%	13%	$4,570,347
2002	86.05%	78%	9%	9%	$5,878,597
2003	87.1%	80%	7%	7%	$5,543,881
2004		Not Available			$2,814,832
Total					**$20,467,906**

According to DHS, Hillside's Medicaid daily rate for June 2004 was $170.65/day, the 18th highest in the state. The highest Medicaid rate was $187.77. Payments from Medicaid went to the operating company, Hillside Health Center, LLC. These payments were used to pay Medicaid allowable expenses including property-related expenses to the company that owned the property, Hillside Health Center Associates, LP and two entities related to Hillside, Sterling Health Care Management Company, LLC and Gregory Building Company. From 1999 to 2003, Hillside Health Center Associates, LP was paid $6,037,266 for property-related expenses of which $2,474,250 was reimbursed by Medicaid and Sterling Health Care

Management Company was paid $1,903,989 from Hillside Health Center Associates, LP of which Medicaid paid $316,615 as allowable costs. (Note: The Medicaid amounts do not include residents' contributions.) Records from DHS show that of Hillside's $13 million mortgage, $5.2 million was allocated for the nursing home portion after the 15-bed conversion increased its capacity to 165 beds.

DHS reported to Task Force staff that although the Hillside facility hovered around the statewide average of 80 percent Medicaid occupancy, its revenues did not reflect the statewide ratio of Medicaid revenues to total revenues of roughly 65 percent.

During the time that Hillside was in operation, Sterling Health Care Management Company also received payments for management services for two other RI nursing homes that Hillside's owner/operators had a business relationship with: Mount St. Francis and Coventry Health Center. From 1999 to 2003, Sterling was paid $2,700,057 for services to Mount St. Francis and from 1999 to 2000, Sterling was paid $1,697,732 for services to Coventry Health Center.

DHS related to Task Force staff that it was important to note that cost reports (BM-64 forms) are not true financial statements. The cost report follows the form required by DHS but submission of standard financial statements to DHS with the cost reports is not required. While not true financial reports, the cost reports do provide financial information that show Hillside was experiencing increasing losses over the years.

A review of Hillside's cost reports show that at the end of 2000, its first full year of operations, Hillside reported expenses of $12,421,539, gross income of $10,247,388, and accounts payable of $4,277,644. On Dec. 31, 2003, its last full year of operation, it reported expenses of $12,127,058, gross income of $10,036,182, and accounts payable of $7,686,996 (The gross income figures reflect adjustment to remove losses from contractual payments noted in the cost reports).

It is not possible to tell from the cost reports if payments of owner's fees were being paid to Hillside's owners. However, Carol Mancini, the court-appointed administrator for Hillside and former CFO for Sterling Health Care Management Company, told Task Force staff in an interview on September 14th, that a check of $34,000 per month was routinely paid to Hillside Health Center Associates as owner's fees in addition to the payments to the management company (Sterling).

The cost reports also show very little income from Hillside's assisted living and adult day care program. The adult day care program was not licensed until June 1, 2001 and, according to the Department of Elderly Affairs (DEA), the licensing agency for adult day services, its highest census was 19 clients. The assisted living programs were licensed in 1999 and HEALTH records show 2002 census levels between 14 and 15 for Kensington Assisted Living and a census of 26 for Winslow Gardens Assisted Living. The cost reports showed income from the assisted living programs in 2003 as $431,805 and $57,324 for the adult day program. Combined this income was only five percent of reported gross income. This is notably less than the projections of 26 percent of revenue coming from the non-nursing home components that were included in the project analysis submitted with the HUD application.

In his comments to the Task Force, Associate DHS Director John Young opined that the reason Hillside failed was its low occupancy rate. He stated that the former administrator had said the facility needed 156 nursing home beds of the165 licensed beds occupied to break even financially. This would have been an occupancy rate of 94.5 percent, an occupancy level which was not achieved in any operational year.

Task Force staff obtained information from the Hillside's court-appointed receiver about claims filed by creditors following the order placing it into receivership. The claims totaled $10,851,000 and are separated into priority claims (taxes) and general claims. Amounts and categories of the larger claims are listed below.

> Priority claims - Total filed: $5,302,000 (taxes)
> (IRS - $3,990,000, City of Prov. - $615,000, RI Provider Tax - $377,000
> State Withholding tax - $199,000, RI Unemployment tax – $118,000)
>
> General claims - Total filed: $5,549,000 (vendor payments, insurances, utilities)
> (Ahlborg Construction-$1,800,000, Consultants Inc.-$870,000,
> Sterling Management Co.-$300,000, A. Giordano-$300,000,
> BC/BS-$152,000, Pharmacy Co.-$106,000, Consultants Inc-$100,000

In discussing the enforcement process for nursing homes, HEALTH staff reported they do not review financial issues as part of the enforcement and survey/inspection process. They are alerted by DHS when issues regarding financing arise so that they can monitor for potential quality of care issues. However, there is no current requirement or standard specifically requiring that financial health of a facility be reviewed as part of the annual licensing survey. There is, however, a state law, (RIGL 23-17-19(a)) - Uniform reports and data systems - that authorizes HEALTH *"with the advice of the Health Services Council, shall also adopt, amend, promulgate, and enforce rules and regulations to provide for a uniform system of reporting detailed financial and statistical data pertaining to the operation, services, and facilities of the health care facilities and the periodic reporting shall, in accordance with the rules and regulations, be concerned with, but not limited to, unit cost utilization charges of health care facility services, financial condition of health care facilities, and quality of health care facility care."* State nursing home regulations address this authority as follows.

> R23-17-18
> 18.26 Each NURSING facility shall report to the licensing agency detailed financial and statistical data pertaining to its operations, services, and facilities. Such reports shall be made at such intervals and by such dates as determined by the Director and shall include but not be limited to the following:
>
> a) utilization of NURSING services;
> b) unit cost of NURSING services;
> c) charges for rooms and services;
> d) financial condition of the facility; and
> e) quality of care.
>
> 18.27 The licensing agency is authorized to make the reported data available to any state agency concerned with or exercising jurisdiction over the reimbursement or utilization of NURSING facilities.

18.28 The directives promulgated by the Director pursuant to these regulations shall be sent to each facility to which they apply. Such directives shall prescribe the form and manner in which the financial and statistical data required shall be furnished to the licensing agency.

1.3. Licensing Standards and Enforcement

Licensing and Survey Process

HEALTH's Office of Facilities Regulation at is responsible for the licensing of health care and assisted living facilities and enforcing of the licensing standards. Currently, there are 100 licensed nursing homes in the state with 10,043 licensed beds. However, only 9,563 licensed beds are active and available as 480 licensed beds are in a "HOLD" category. They have been taken out of service by the licensee as allowed under state law (RIGL 23-17-44 (b)) and are not included when computing state occupancy rates for Medicaid payment purposes. Most of the homes are dually certified for both Medicare and Medicaid. DHS reported that the official statewide occupancy, based on 2003 cost reports, was 92.2 percent (Nov. 10, 2004 email from Frank Spinelli, DHS Administrator for Adult Services, to M. Maigret).

To a great degree the survey and enforcement process for nursing homes is controlled by a set of prescriptive federal protocols that checks for compliance with the hundreds of federal and state requirements nursing homes must follow. These protocols are contained in the Centers for Medicare and Medicaid (CMS) State Operations Manual (SOM). The federal licensing standards were enacted in 1987 and include most recommendations made in a 1986 Institute of Medicine report on Nursing Home Reform. Under federal protocols, state surveyors assess both the process and the outcomes of nursing home care in 15 major areas. Each of these areas has specific regulations which state surveyors review to determine whether or not facilities have met the standards. In July 1995, the federal government consolidated its 325 measures of quality to a total of 185 measures. That same year, the federal government initiated a new enforcement process for the system. Under the regulations, nursing home providers must remain in substantial compliance with state law and Medicare/Medicaid program requirements; all deficiencies must be addressed promptly; and residents must receive the care and services they need to meet their highest practicable level of functioning.

To enforce the federal standards, CMS contracts with the state to perform the inspections of Medicare and Medicaid certified nursing homes and federal funds pay for approximately 75 percent of the cost of the surveys. Under federal law each nursing home must be surveyed annually. Inspections are unannounced, although not unpredictable, as they can be expected to occur anytime between nine and 15 months from the last annual survey. At least 10 percent of the surveys must be conducted at night or on weekends and HEALTH reports that it exceeds this requirement. By law, CMS must conduct validations surveys of at least five percent of the number of certified nursing homes annually in each state. CMS also conducts performance evaluations of other aspects of the survey process to determine if the state is in compliance with survey requirements and protocols.

Survey staff are trained and certified in accordance with federal requirements. A multi-disciplinary survey team, including at least one RN, must conduct the survey. Residents who are reviewed as part of the survey are selected based on prescribed sampling techniques and other criteria. When deficiencies are found they are assigned a rating based on a scope and

severity scheme (See Appendix C) which is also used to guide enforcement recommendations and actions. At the end of the on-site survey, the team conducts an exit interview with the nursing home staff to discuss preliminary findings. The long-term care ombudsman, one or two residents and resident council officer of are supposed to be invited to attend the exit conference. The survey team reports the preliminary findings to supervisory staff for review and modification prior to completion of the final report. When complete, the survey report is mailed to the nursing home.

The survey report must be made available to the public 14 days from the date it is made available to the nursing home. If more than minimal deficiencies are found, the nursing home must prepare a Plan of Correction (POC) and submit the POC to the state within 10 days of receiving the survey. According to federal policy, the POC serves as the facility's allegation of compliance. Federal policy also requires that the survey report and POC be provided to the state long-term care ombudsman who must also receive information on any adverse action taken against a nursing home. State regulations require that the nursing home administrator provide copies of all deficiency statements of related POC's to the medical director in a timely fashion. The administrator must also notify the medical director immediately when certain enforcement orders are issued by HEALTH or CMS or when the administrator is notified of any Medicare/Medicaid certification enforcement action. A copy of the most recent survey report must be available to residents in an accessible place and a notice of the availability of the survey must be posted.

Upon receipt of its survey results, the nursing home must be offered one informal opportunity, if requested, to dispute deficiencies. This request must be made within the timeframe the nursing home has to file its plan of correction.

Based on survey findings, the state has a number of federally prescribed optional or required enforcement actions which it recommends to CMS, in the case of the federal process (See Appendix C), or which it can impose under state law. The federal sanctions must be approved by the CMS regional office. Depending on the survey findings they may include: a directed plan of correction; directed in-service training; civil monetary fines; denial of new admissions; denial of payment for all individuals; termination of certification; state monitoring; appointment of temporary management; transfer of residents; and closure.

In certain cases of serious deficiencies, such as when "Actual Harm" is found on two sequential surveys, a federal **"NO OPPORTUNITY TO CORRECT (NOC)"** sanction is imposed**.** Under "NOC" the nursing home's Medicare provider agreement is terminated if the facility has not achieved substantial compliance six months from the last day of the noncompliant survey, meaning the nursing home will no longer be able to participate in Medicare. This notice was given to Hillside following its November 2003 survey and thus the six-month (180 day) clock started to run.

If, during a survey, "Substandard Quality of Care" is identified the state must notify the state Board of Nursing Home Administrators and the attending physician of each resident who was identified as having received "Substandard Quality of Care". Federal law also provides that a state "may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and

preserving evidence, and carrying out appropriate enforcement actions against substandard skilled nursing facilities." (SSA Act Section 1819 (g))

When "Immediate Jeopardy" to resident health or safety is suspected during a survey, state supervisory staff are immediately notified. If confirmed, HEALTH invokes the "Immediate Jeopardy" process and the facility must submit a response detailing how and when the "Immediate Jeopardy" was or is being removed. If "Immediate Jeopardy" is not removed, the survey agency must complete termination procedures within 23 days from the last day of the survey which found the immediate jeopardy. Under federal law, a temporary manager may be imposed as an alternative to, or in addition to, ordering termination when immediate jeopardy is cited.

To determine if the nursing home is in compliance after the survey, revisits are generally conducted based on federal- and state-recommended schedules and protocols. If more than two revisits are conducted, CMS must approve them in order for the state to receive federal reimbursement. The state can adopt a more rigorous revisit policy using its own resources. The CMS manual states that the "purpose of the post-survey revisit (follow-up) is to re-evaluate the specific care and services that were cited as noncompliant during the original standard, abbreviated standard, extended or partial extended survey(s)." The follow-up visit looks at the status of corrective actions being taken regarding all citations of substantial non-compliance and the facility's plan to monitor its performance in identifying the deficient practice/care and ensuring that it does not recur. However, the team is not prohibited from gathering information related to any requirement during a post-survey revisit.

Federal regulations also allow the state to request a state monitor to oversee the correction of cited deficiencies in a nursing home as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred is an optional federal remedy the state can request. The SOM states that situations where it may be appropriate are: poor facility compliance history, e.g., a pattern of poor quality of care, many complaints, etc., and state concern that the situation in the facility has the potential to worsen.

Several federal reports have cited complaints about lax and/or irregular enforcement and enormous interstate variation in survey results.

> A DHHS OIG report (March 2003 OEI-02-01-00600, *Nursing Home Deficiency Trends and Survey and Certification Process Consistency*) reviewed 310 survey reports and found different deficiency tags being used to cite the same problem. In five of the six standard surveys observed, the OIG found inconsistency across surveyors in how deficiencies were cited, and also found differences across states in how many deficiencies they will cite for a single problem of non-compliance. This inconsistency in state agencies' review processes is reflected in the wide variation in revisions made to draft deficiency reports. State agencies report that an average of five percent of deficiencies are removed from draft survey reports before they become final. However, this removal rate ranges from 25 percent in one state to nothing in three other states. RI's removal rate was reported to be 10 percent of the deficiencies. Further, state agencies report that an average of six percent of scope and severity determinations are downgraded from draft surveyors' reports before they become final. This ranges from one state that reports 38 percent of deficiencies are downgraded to two states that say no deficiencies are downgraded.

A 2003 Government Accounting Office (GAO) study (*Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, GAO-03-561) is highlighted below.

> The magnitude of documented serious deficiencies that harmed nursing home residents remains unacceptably high, despite some decline. For the most recent period reviewed, one in five nursing homes nationwide (about 3,500 homes) had serious deficiencies that caused residents actual harm or placed them in immediate jeopardy. Moreover, GAO found significant understatement of care problems that should have been classified as actual harm or higher—serious avoidable pressure sores, severe weight loss, and multiple falls resulting in broken bones and other injuries—for a sample of homes with a history of harming residents. Several factors contributed to such understatement, including confusion about the definition of harm; inadequate state review of surveys to identify potential understatement; large numbers of inexperienced state surveyors; and a continuing problem with survey timing being predictable to nursing homes. States continue to have difficulty identifying and responding in a timely fashion to public complaints alleging actual harm—delays state officials attributed to an increase in the volume of complaints and to insufficient staff. Although federal enforcement policy was strengthened in January 2000 by requiring state survey agencies to refer for immediate sanction homes that had a pattern of harming residents, many states did not fully comply with this new requirement, significantly undermining the policy's intended deterrent effect. While CMS has increased its oversight of state survey and complaint investigation activities, continued attention is required to help ensure compliance with federal requirements. In October 2000, the agency implemented new annual performance reviews to measure state performance in seven areas, including the timeliness of survey and complaint investigations and the proper documentation of survey findings.

A 2004 report, ***Nursing Facilities, Staffing, Residents, and Facility Deficiencies 1997-2003*** (C. Harrington, H. Cerrillo and C. Crawford, August 2004, University of California, San Francisco), shows deficiency rates for Rhode Island (2003) below average for the country (4.4 per home in RI, 6.9 per home national average). This report also showed that in 2001, 21.8 percent of the state's nursing homes were deficiency free and in 2003 the state deficiency free rate was 11.1 percent. The OIG report noted above showed RI as having the second lowest percent of deficiencies/nursing home in the country. The 2003 GAO report noted above showed that from July 2000 to January 2002, 20.5 percent of the nation's nursing homes were cited for "Actual Harm" or "Immediate Jeopardy". The rate for RI nursing homes was 10.1 percent.

Rhode Island law (RIGL 23-17-12) goes beyond the federal requirement of at least one annual survey by requiring all nursing homes to have two additional surveys per year. Facilities cited for substandard care must undergo bimonthly inspections for one year following the finding of substandard care. The statute also mandates that the HEALTH director promulgate regulations regarding criteria to determine frequency of surveys using patient acuity, quality indicators and a facility's past compliance. The Task Force found nothing in state regulations regarding such criteria.

State law also gives the HEALTH Director additional authority to enforce nursing home standards and/or to protect residents. RIGL 23-1-21 - Immediate compliance order – gives the director authority to take immediate action to protect the health, welfare, or safety of the

public or any member of the public by issuing an immediate compliance order, without prior notice of violation or hearing. The compliance order becomes effective immediately upon service or within the time specified in the order. This statute was used by the director in the recent past to stop admissions to two nursing homes found to have care issues. In addition, RIGL 23-17-8.1, - Licensing of Health Care Facilities - empowers the HEALTH Director "to take any other corrective action necessary to secure compliance with the requirements established under this chapter". State nursing home regulations (R23-17-22.5) also allow the Director to require nursing staff increases at a home. Under the state Principles of Reimbursement, Medicaid may cover the expense of additional nursing staff ordered by HEALTH.

> 22.5 Whenever the licensing agency determines, in the course of inspecting a facility, that additional staffing is necessary on any nursing unit to provide adequate nursing care and treatment or to ensure the safety of residents, the licensing agency may require the facility to provide such additional staffing and any or all of the following actions shall be taken to enforce compliance with the determination of the licensing agency.
>
> a) The facility shall be cited for a deficiency and shall be required to augment its staff within 10 days in accordance with the determination of the licensing agency.
> b) If failure to augment staffing is cited, the facility shall be required to curtail admission to the facility.
> c) If a continued failure to augment staffing is cited, the facility shall be subjected to an immediate compliance order to increase the staffing, in accordance with section 23-1-21 of the General Laws of Rhode Island of as amended.
> d) The sequence and inclusion or non-inclusion of the specific sanctions enumerated in sections above may be modified in accordance with the severity of the deficiency in terms of its impact on the quality of resident care.

Another Rhode Island law intended to protect nursing homes residents, RIGL 23-17.11. - THE EMERGENCY SKILLED NURSING AND INTERMEDIATE CARE FACILITIES ACT – provides for the HEALTH Director to petition Superior Court for receivership in certain circumstances. This law was enacted in 1988 following difficulties with care at a specific nursing home but, to date, has not been used. Section 23-17.11-6 of the law gives authority to the HEALTH Director to petition Superior Court for the appointment of a receiver in the event of mismanagement.

> **23-17.11-6. Mismanagement of facility.**
>
> (a) Whenever the director shall determine that a facility is being operated in a manner which will have a detrimental impact on the health, safety, or well-being of any residents of a facility, and that the appointment of a receiver would facilitate the protection of health, safety, or well-being of the residents of the facility, the director shall petition the superior court for the appointment of a receiver.

This law was enacted in 1988 following difficulties with care at a specific nursing home but, to date, has not been used. However, HEALTH has recently indicated that this could have been used with regard to Hillside and has since requested that the Attorney General look to use this law to place Mt. St. Francis in receivership.

The role of HEALTH in providing consultation and assistance to nursing homes in correcting problems was an issue brought up at Task Force meetings. HEALTH staff clearly stated and

CMS policy confirms that consultation on improving care and correcting problems is not a function of the survey process. However, information transfer about care and regulatory requirements is required. A CMS Memo (Ref: S&C-03-08 from Director, Survey and Certification Group to Associate Regional Administrators and State Survey Agency Directors) states, *"The nursing home is responsible for correcting deficiencies…..It is not the surveyor responsible to delve into the facility's policies and procedures to determine root cause of the deficiency or to sift through various alternatives to suggest an acceptable remedy."* It further states, *"State Health Facility Surveyors, however, should not act as consultants to nursing homes."* The CMS SOM Appendix P, Survey Protocols for Long Term Care Facilities states:

> **IX. Information Transfer**
> In conjunction with conducting surveys, the State should provide information to the facility about care and regulatory topics that would be useful to the facility for understanding and applying best practices in the care and treatment of long term care residents.
>
> This information exchange is not a consultation with the facility, but is a means of disseminating information that may be of assistance to the facility in meeting long term care requirements. States are not liable, nor are they to be held accountable if training which occurs during information transfer does not "correct" problems at the facility.
>
> Performance of the function is at the discretion of the State and can be performed at various times, including during the standard survey, during follow-up or complaint surveys, during other conferences or workshops or at another time mutually agreeable to the survey agency and the facility. The time allotted for this information transfer should not usually exceed one hour. In no instance should the information transfer delay the survey process.

Recognizing the limitations and restraints of the survey process, several states have supplemented their quality assurance standards with consultative, collaborative programs that directly address quality improvement. A federal study examined seven states with non-monetary state-initiated quality improvement efforts (US DHHS, State Nursing Home Quality Improvement Programs: Site Visit and Synthesis Report, May 15, 2003). The programs included technical assistance, training, public recognition and public reporting. The study generally found positive impact reported by participants in programs providing technical assistance and that staff had been able to establish a more collaborative, less adversarial relationship with nursing facilities than is typical for surveyors.

Hillside Surveys and Enforcement

The Report to the Governor, **Review of Department of Health's Response to the Quality of Care at Hillside Health Center,** describes in great detail the actions of HEALTH Facilities Regulation staff following its annual inspection on Nov. 4, 2003 and follow-up visit on Dec. 19, 2003, when it found substandard care in relation to pressure ulcers, and the serious care issues involving the resident now referred to as Resident #1 on later revisit surveys. This activity included a total of 71 visits from Nov. 4, 2003 through June 6, 2004 when Hillside closed. The reports of Hillside's post-November 2003 surveys (excluding the monitoring reports) were reviewed by the Task Force as were the extensive follow-up activities of HEALTH as documented in the Report to the Governor, so they will not be summarized here. This report, however, will reference and discuss them in its findings.

This Task Force also reviewed inspection reports prior to the Dec. 19, 2003 visit when the

state first found Substandard Quality of Care at Hillside. Staff also was provided information, as allowed by law, on complaints reported to HEALTH by the state long-term care ombudsman (LTCO) who, over several years, made numerous complaints about Hillside to HEALTH. These reports show a disturbing picture of a nursing home that was unable to stay in substantial compliance with licensing requirements and a range of complaints that covered everything from the competency of the administrator to reports of ongoing financial difficulties. A review of these surveys, as summarized below, reveals early on a pattern of problems relating to quality-of-care issues, such as pressure ulcers and nutrition/hydration. Although the required follow-up revisits would find the nursing home had corrected the problems, the record shows they were unable to remain in substantial compliance. This is referred to as the "Yo-Yo" effect. The review also shows that in several instances the enforcement recommendations made to CMS by HEALTH were reduced to less stringent ones.

Summary of pre-December 2003 surveys and LTCO complaints

January 19, 2000 (annual survey) - 8 deficiencies
Enforcement action: HEALTH ordered a Directed Plan of Correction. **March 21, 2000** – (revisit) corrected

December 1, 2000 (annual survey) – 6 deficiencies (including 1 at F level for widespread sanitary conditions and 1 at G level, actual harm, for pressure ulcers)
Enforcement Action: HEALTH recommended penalty of $800/day, CMS imposed Opportunity to Correct. **January 30, 2001** (revisit) - corrected

July 2001 – Complaints reported to and by LTCO
July 16
State LTCO met with administrator regarding lack of staff on Alzheimer's unit. Administrator responded that staff were probably sleeping on the weekend and he and the nursing director had caught them before. Administrator stated he could not fire staff as corporation and their lawyer would not allow this due to ongoing union activities.

July 17 and 18
Anonymous complaints made to LTCO regarding the Alzheimer's unit. Concerns related to lack of staffing, lack of activities, un-cleanliness, residents not being fed, and restraint issues.

July 20
Anonymous complaint regarding serious conditions on Alzheimer's unit reporting residents had bruises of unknown origin, unclean conditions, medications being left on tables and improper feeding. Alliance/LTCO staff did a walk through of Alzheimer's unit. Among the findings:

Horrific odor
(2) Residents with restraints on in dining room
No staff in dining room with residents
Very loud rap music on in dining room
Dining room was dirty, food on floor, tables not cleaned
(3) Out of (4) residents at table had had no nail care
For about 20 minutes, only staff observed were (1) nurse and (2) CNAs
At 6:30 at night, half of residents were already in bed
No activities taking place for those who were awake,

all of whom were noted to have pedal edema
(1) Resident receiving bedtime care was fully exposed with no cover
Huge puddle of water in middle of hallway was brought to staff attention and staff said this leak happens often
Windows had stops on bottom section of window to prevent window from opening too far, however top of the windows were pulled down all the way, and there was no stop to prevent them from opening

July 25
Alliance/LTCO letter to DOH regarding conditions found during walk-through described above. Alliance said they would try to get Volunteer Ombudsman in place.

August 8, 2001 – a complaint survey found 4 deficiencies including 2 at G level, actual harm, for nutrition and hydration
Note: These deficiencies are referred to as a "Double G" as the prior survey had also found a level G deficiency
Enforcement Action: HEALTH recommended $900 per-day CMP, denial of payment and termination; CMS imposed $2,000 per-instance CMP and agreed with HEALTH's other recommendations. CMS reports a CMP of $1300 was paid. **September 12, 2001** (revisit) - corrected

LTCO complaint
September 12, 2001
Alliance/LTCO sent letter to Nursing Home Administrator's Board regarding Mr. Janetakos' (administrator) failure to protect resident rights and growing number of complaints about Hillside

November 8, 2001 (annual survey) – 6 deficiencies (including 1 at F level for widespread sanitary conditions)
Enforcement Action: HEALTH recommended Denial of payment for new admissions; CMS provided Opportunity to Correct. **December 12, 2001** (revisit) - corrected

LTCO complaint
February 2002
LTCO Notes: Volunteer ombudsman (VOP) was denied a walk through the nursing home who said administrator said they were being targeted. Alliance had to call administrator and owner's representative to say this is allowed under federal law and LTCO staff met with administrator and facility's attorney at which time administrator admitted to being afraid and was shaking visibly and stated he had no control of operations and it was all done from Broad St. It was agreed VOP would be able to come and go and would work with the DNS.

July 3, 2002 (Complaint follow-up survey) - 2 deficiencies found in the Alzheimer's unit for failure to lock the medication cart and for non-working air conditioners which had been broken all summer. **August 1, 2002** (revisit) – Corrected

August 2002 LTCO complaints and activity
August 8, 2002
LTCO Reported to DOH that vendors were complaining about past-owed accounts. Now all are on COD. This was also reported to DHS office and AG's office. The DNS has been out for 2 weeks and there is a rumor she is not returning. Other nurses have left and the place is short staffed. The administrator is staying in his office with door

shut and not coming out. Another caller reported that it is believed the nursing home uses time cards of people who do not exist.

August 14, 2002
LTCO reported to DOH on calls it received from (2) family members with complaints about not having staff and pool nursing staff not being called in. Also no air conditioning, no drinks, residents dressed inappropriately for heat. DOH response was that they would discuss with clinical supervisor and get back to Alliance. DOH staff noted that last time he was there, administrator started crying.
Ombudsman note shows this comment: **ANOTHER EDMUND COMING!**

August 15, 2002
LTCO call to Office of Facility Regulation to report as above but that it was hotter; families upset as no water is being passed; resident's overheard asking for drinks; Alzheimer's floor smells really bad

August 16, 2002
HEALTH staff called Alliance to say a RN went out on the 15th and will go back in today and another will go back in afternoon.

August 15, 2002 (complaint survey) – "E" level (pattern) deficiency related to pharmacy services, drug shortages
Enforcement Action**:** State recommended Directed Plan of Correction, CMS recommended opportunity to Correct. **September 13, 2002** (revisit) –Corrected

LTCO complaint
October 4, 2002
Complaint received from family member regarding neglect of a resident needing skilled care who ended up in hospital in ICU with dehydration, infection and renal failure who later died. Family did not file official complaint with DOH, but this was reported by LTCO.

October 28, 2002 (annual survey) – 17 deficiencies found (including 1 G level related to Nutrition in which 2 residents experienced significant weight loss; 1 level D for Quality of Care for failure to notify the physician as ordered on 2 insulin-dependent residents when blood sugar tests fell outside of range – in one case the physician was not notified on 43 occasions over three weeks and in the other the physician was not notified in a majority of the 37 times; 1 level F for widespread issues relating to dietary services; 1 level E for issues relating to assessment of pain medication; and 1 level D for Activities of Daily Living for a resident with weight loss in need of supervision with diet)
Enforcement Action: HEALTH recommended CMP of $800 per day, CMS imposed Opportunity to correct. **January 16, 2003** (revisit) - corrected.

October & November 2002 LTCO activity
October 28, 2002
Alliance/LTCO responds in writing to HEALTH to survey results of 10/28/02 showing 26 pages of deficiencies and noting concern regarding resident's quality of life and life being jeopardized by nursing home practices. Issues include failure to control pain; lack of privacy; lack of infection control measures; failure to provide/obtain physician orders for treatment; failure to follow care plans; inadequate resident assessments; discrepancies in medication management. Most disturbing is the severe weight loss of some

residents. One lost 16 lbs in 18 days, another 11 lbs in (3) months and a third, 22.5 lbs in (6) months. Alliance requested immediate attention as residents needed action to protect their well-being.

November 11, 2002
LTCO received a complaint from family about resident who was now unresponsive in hospital with skin breakdown and other serious problems. Alliance Clinical Director found many questions regarding resident's clinical care at nursing home including appropriateness of medications. Patient was eventually discharged to another nursing home, but had to return to hospital and died there.

The Oct. 28, 2002 survey is noteworthy for several reasons. Despite the many serious quality of care problems found, these were not determined to be Substandard Quality of Care, as defined by federal standards. If, in fact, substandard care had been assigned, under state law, the home would have subject to inspections on at least a bi-monthly basis for the next twelve months and, possibly, the deteriorating care would have been identified and prevented. It is also an example of the difficulty of the nuances involved in determining "Immediate Jeopardy" versus "Actual Harm". In the case of one resident cited for "Actual Harm" under the nutrition category, it was stated that a weight loss of 16 lbs. over 18 days had occurred from a baseline weight of 108 lbs. The resident had a feeding tube but was to be offered oral intake. The survey found her fluid intake sheet was incomplete, the facility had failed to do a weekly weight check following an 8 lb. weight loss over the prior two weeks and the dietician was not notified of the situation. There was nothing in the (POC) to note that due to the resident's condition this type of weight loss was expected or that it could not be prevented. In fact, the POC stated that the "current enteral feeding will allow 1-2 lb. weight gain per week". The Task Force did not have the resident's medical record to review, however, it did ask HEALTH why a weight loss of this magnitude was not considered "Immediate Jeopardy". A HEALTH supervisory staff member responded that, based on her review of the record, the level of G ("Actual Harm") was given (as opposed to J, "Immediate Jeopardy") "because there was a lack of documentation in what the facility did or didn't do. Whether the resident was going to lose weight or not based upon that documentation was unable to be determined by the review."

Despite the serious quality of care issues found in the October 28 survey report, **the nursing home was not surveyed again until Nov. 4, 2003, some nine and one-half months following the revisit of Jan. 13, 2003.** HEALTH staff reported that they had received no complaints during this time to warrant an immediate visit. (In fact, 13 complaints were received during that time period but HEALTH's policy is to only immediately investigate only those resulting in harm). The fact that the nursing home had such poor survey results on its last annual survey and repetitive complaints filed by the LTCO was apparently not considered sufficient to warrant closer attention.

November 4, 2003 - 23 deficiencies found (3 at level A, 5 at level C, 10 at level D, 2 at level E, 2 at level F, and 1 at level G). Pressure ulcers (F314) at the isolated "Actual Harm" level was documented as the nursing home's failure to ensure nine residents (26% of the sample observed) received the care and treatment necessary to promote healing of sores and prevent sores from occurring. This included dressings not applied and stage II pressure ulcers not documented. Task Force staff inquired as to why this was rated as a G level and not an H level

(indicating pattern) which would have triggered "Substandard Quality of Care". A document showing case profiles of enforcement provided by the regional CMS office showed that the regional office had changed the rating to "H" but this was not apparently relayed to the state office. The regional profile document included the following comments regarding this deficiency. "It is this analyst's opinion that this deficiency shows a pattern should have been assigned a scope and severity of "H" at a minimum". In addition, the analyst questioned that another deficiency relating to foot care should have been rated at a "G" level and noted that **"At a minimum this facility is providing substandard quality of care under F314."** The analyst asked a federal surveyor to review the case. The federal surveyor determined that pressure ulcers (F314) was at a minimum H, and she questioned why it wasn't potential jeopardy. The federal surveyor also agreed that one of the foot problems that was oozing yellow drainage without staff being aware should have been a "G". In inquiring about this change in assignment of scope and severity with HEALTH staff, they noted that when the regional office changed the designation from "G" to "H", it did not follow its own protocol nor did it inform the state regarding the change.
Enforcement Action: HEALTH recommended $1,000 per day CMP, denial of payment and termination. CMS imposed CMP of $250/day and no opportunity to correct.
December 19, 2003 (revisit) – "Substandard Quality of Care" cited

The November 4th survey again demonstrates the variation and difficulties in assessing deficiencies relating to "Substandard Quality of Care". Despite such poor performance, the federal scheme as implemented by HEALTH did not support the assignment of "Substandard Quality of Care" which was cited on the revisit that took place six weeks later.

Complaint Investigation and Reporting of Abuse/Neglect
The Task Force is concerned with the timeliness of HEALTH's follow-up to reported complaints. It is also concerned with the fact that there are a number of reporting requirements with differing provisions related to the time in which investigations should be done and whether the various efforts by agencies are coordinated, efficient and effective. A summary of the various reporting requirements follows.

RIGL 23-17.8 – Abuse in Health Care Facilities – requires anyone who in their professional capacity or within the scope of their employment at a facility has knowledge of or reasonable cause to believe that a patient or resident in a facility has been abused, mistreated, or neglected to make a report, by telephone, to HEALTH (and MHRH in some instances) within twenty-four (24) hours or by the end of the next business day. Reporting parties have the option of making the report to a high managerial agent of the facility instead of HEALTH. The telephone reports must be followed-up within three (3) business days with a written report. If a report is received from a facility by a person other than a physician or a certified registered nurse practitioner or physician assistant, the facility must have the patient examined by a licensed physician or a certified registered nurse practitioner or physician assistant. Failure to report constitutes a misdemeanor. Other persons not required to make a report may make one.

Under RIGL 23-17.8, HEALTH and MHRH must investigate and evaluate the reports within twenty-four (24) hours if they have reasonable cause to believe the patient's or resident's health or safety is in immediate danger from further abuse and neglect and within seven (7) days for all other reports. RIGL 23-17.8 also requires facilities to post these reporting requirements in a conspicuous place on each floor of the health care facility.

Federal regulations also require that complaints be reported to HEALTH including complaints reported by providers which the federal government refers to as "incidents". Federal standards require that any complaint involving "Immediate Jeopardy" be investigated within 48 hours. However, the federal protocol also provides that if a state has a shorter timeframe, then the CMS regional office would accept the timeframe of the state law and suggests that attempts should be made to integrate the state and federal processes. States must use CMS' ASPEN Complaints/Incidents Tracking System (ACTS) software program to track, process, and report on complaints and incidents.

HEALTH reports that under its intake triage process, a complaint is assigned "Immediate Jeopardy" priority if the intake information indicates immediate corrective action is necessary because serious injury, harm, impairment or death to a resident, patient or client has, or is likely to occur. "Immediate Jeopardy" (IJ) and serious and immediate threat are interchangeable terms. If a complaint is assigned "IJ" it is immediately referred to regulatory supervisory staff.

Federal timeframes for reporting other complaints vary are as follows and differ from the state reporting requirements provided in under RIGL 23-17.8 as follows:

> "Non-Immediate Jeopardy" – High - defined as harm that impairs mental, physical and/or psychosocial status - Investigate within 10 days
>
> "Non-Immediate Jeopardy" – Medium - defined as harm or potential of more than minimal harm that does not significantly impair mental, physical and/or psychosocial status - Investigate within 45 days
>
> "Non-Immediate Jeopardy" – Low - defined as discomfort that does not constitute injury or damage - Investigate within 120 days
>
> "Administrative Review/Offsite Investigation" – Intake triage determines complaint/ incident as not needing an onsite investigation.

Federal protocol provides for the privacy and anonymity of every complainant and HEALTH is only permitted to disclose the complainant's identity to those individuals with a need to know who are acting in an official capacity to investigate the complaint.

Rhode Island law (RIGL 42-66-8 - Abuse of elderly persons - Duty to report) also requires any person who has reasonable cause to believe that any person sixty (60) years of age or older has been abused, neglected, exploited, or abandoned immediately report it to the director of the DEA or his or her designee. Failure to make the report is punishable by a fine of not more than one thousand dollars ($1,000) or imprisonment for a term of not more than one year, or both.

HEALTH reports the following complaint data for state fiscal years 2003 and 2004 and noted that in 2004 CMS required a new system for reporting complaints that separates complaints filed by the nursing home from those filed by other sources. Those filed by nursing homes are termed "incidents".

State Fiscal Year	2003	2004
Complaints reported	692	353
Complaints investigated	684	362
Complaints substantiated	181	102
Complaints administratively closed	0	4
Incidents reported		683
Incidents investigated		389
Incidents administratively closed		214
Incidents substantiated		N/A

Complaint investigation is one area by which CMS evaluates the state survey agency's performance. In 2002, HEALTH met all the federal standards for complaint investigation. In its 2003 evaluation, however, CMS noted several areas in which the state did not meet CMS performance standards. One was its failure to investigate a case of "Immediate Jeopardy" within the required two-working-day timeframe. Another was that it did not meet the requirement that 95 percent of complaints involving "Actual Harm" be investigated within 10 days. CMS found three complaints of "Actual Harm" which were investigated in 32 days, 34 days and 14 days respectively. HEALTH filed a plan to address the issues raised in the performance evaluation in which it noted that it disagreed with some of the CMS designations of "Actual Harm" and that resources were a barrier to meeting the requirements. (Note: Copies of the 2002 and 2003 performance evaluation reports were made available to the Task Force by the regional CMS office.)

In addition to the state and federal mandates for reporting of nursing home abuse and complaints, both federal and state law relating to residents rights provide that residents have the right to voice grievances and requiring for the nursing home to take prompt action to address the grievances. (42 CFR 483.10(f) and state regulation R23-17.5). Nursing homes are required to inform each resident, orally and in writing, at the time of admission to the facility, of the resident's legal rights during their stay at the facility and must make available to each resident, upon reasonable request, a written statement of such rights. The nursing home must also post a copy of the provisions of the resident rights law in a conspicuous place in each nursing home and the posting must include the address and phone numbers of the HEALTH complaint division; the long-term care ombudsman and the state Medicaid Fraud agency. This posting is not required on each floor.

In addition to these reporting processes, the federal and state law mandating the Long-Term Care Ombudsman Program (LTCO) provides that persons can complain to the LTCO and requires the LTCO to work to address these complaints.

> **RIGL 42-66.7-4. Long term care ombudsperson.**
> The department of elderly affairs shall establish the position(s) of long term care ombudsperson for the purpose of advocating on behalf of long term care facility residents and of receiving, investigating and resolving through mediation, negotiation, and administrative action complaints filed by residents of long term care facilities, individuals acting on their behalf or any individual organization or government agency that has reason to believe that a long term care facility, organization or government agency has engaged in activities, practices or omissions that constitute a violation of applicable statutes or regulations or that may have an adverse effect upon the health, safety, welfare, rights or the quality of life of residents of long term care facilities. The department

of elderly affairs may operate the office of long term care ombudsperson and carry out the program, directly or by contract or other arrangement with any public agency or non-profit organization.

State law provides that the LTCO shall *"Make appropriate referrals of investigations to other state agencies, such as the department of health and the department of attorney general;"* It also states that *"The files maintained by the long term care ombudsperson program are confidential and shall be disclosed only with the written consent of the resident client affected or his or her legal representative, or if any disclosure is required by court order. Nothing in this paragraph shall be construed to prohibit the disclosure of information gathered in an investigation to any interested party as may be necessary to resolve the complaint or to refer to other appropriate state agencies investigating civil, criminal or licensing violations."*

The state LTCO law was enacted in 1995 and is modeled on the federal LTCO program mandated in the Older Americans Act. State law requires DEA establish an interagency agreement among the DEA, HEALTH, the Attorney General's Department and DHS to ensure a cooperative effort in meeting the needs of the residents of long term care facilities. To date, this agreement has not been established.

Family/Resident Involvement and Notice

On July 21st, the Task Force held a public meeting for the purpose of hearing from family members and former Hillside staff. Family members spoke of the need for better communication and the need for family input. They reported that conditions at Hillside had been going downhill for the past two years but that many families were not aware of the severity of the conditions there until March when the receiver was appointed. A family member stated that if families had been notified following the November 2003 survey that Hillside would close in 180 days if it did not come into compliance that perhaps they could have worked together to get a new administrator sooner and Hillside could have been saved. Family members said the state website on nursing home deficiencies did not have timely information and suggested that each nursing home have its own website that would both include survey reports and be used to notify families of issues and actions being taken. They reported that their loved ones were fearful of retaliation if they complained to staff and pointed to the unresponsiveness of some of the professional nursing staff. When family members would bring concerns up at family meetings, there was little follow-up in addressing their concerns.

Federal and state law require that family members and a resident's physician be notified when a resident's condition changes. Federal regulations additionally require that the resident, interested family member (if known) or the resident's legal representative and resident's physician be notified of accidents resulting in injury; the need to significantly alter treatment or a decision to transfer or discharge a resident. There is no requirement that any notice, other than posting of survey reports, be provided to families when a nursing home has been cited for "Substandard Quality of Care" or when an enforcement action is imposed that could result in closing the nursing home if remedial action is not taken. In the case of Hillside, state monitoring was ordered when a resident was found to be in "Immediate Jeopardy" due to pressure ulcers. The family was not notified of the finding of "Immediate Jeopardy" or of the order for state monitoring.

Federal law provides that residents have the right to organize and participate in resident groups in the facility and that a resident's family has the right to meet in the facility with the families of other residents in the facility. The facility must provide a resident or family group, if one exists, with private space and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. The survey protocol also requires that interviews with family councils, if they exist, be conducted.

In RI, the state Alliance for Better Long Term Care and LTCO have worked to promote and assist in the establishment of resident and family councils. Several states have been identified by the National Nursing Home Reform Coalition as having enacted state laws that codify and strengthen federal requirements for family/resident councils. Some states have formed resident/family council networks or information exchanges as a way to learn from each other and to advocate on a statewide basis. (http://www.nccnhr.org/public/245_1265_8308.cfm#md). The Task Force is not aware of any current efforts to bring together family/resident council representatives in RI for such purposes although the Alliance for Better Long Term Care has done this in the past.

Staffing Issues

Federal law requires nursing homes to provide "…sufficient nursing staff to attain or maintain the highest practicable … well-being of each resident". Beyond this, federal standards require a minimum of 8-hours of RN and 24-hours of licensed nurse coverage per day. Rhode Island law exceeds this requirement by mandating that an RN be on duty 24 hours per day.

Reports to the Task Force indicate that Hillside had at least five Directors of Nursing and an unstable workforce during its operations. The CMS Nursing Home Compare website contains data on number of nursing staff hours per day. The chart for Hillside, reproduced below, shows Hillside was significantly below the national and state averages. HEALTH staff reported that the data was self-reported by the facility at the time of the survey (10/31/03). Task Force staff reviewed a copy of the data sheet submitted to HEALTH for the Report (CMS-671) and confirmed the figures were consistent with the data reported on the website.

Nursing Staff Hours Per Resident Per Day -- Hillside

	HILLSIDE HEALTH CENTER	State Average in Rhode Island	National Average
Number of Residents	140	91.4	89.4
RN Hours per Resident per Day*	0.14	0.7	0.7
LPN/LVN Hours per Resident per Day*	0.23	0.4	0.8
CNA Hours per Resident per Day*	0.5	2.2	2.4
Total Number of Nursing Staff Hours per Resident per Day*	0.87	3.3	3.9

*Hours per resident per day is the average daily work (in hours) given by the entire group of nurses or nursing assistants divided by total number of residents. The amount of care given to each resident varies. (http://www.medicare.gov/NHCompare/include/DataSection/ResultsSummary)

Under Congressional directive, the federal government conducted research and reported on the appropriateness of nurse staffing ratios in nursing homes. The report, Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final, Volume I (Dec. 24, 2001) states:

> Strong evidence supports the relationship between increases in nurse staffing ratios and avoidance of critical quality of care problems. Above identified nurse staffing thresholds, however, increased staffing does not result in improved quality. Depending on the nursing home population, these thresholds range between 2.4-2.8, 1.15-1.30, and 0.55-0.75 hrs/resident day for nurse aides, licensed staff (RNs and LPNs combined), and Registered Nurses, respectively. Although no significant quality improvements are observed for staffing levels above these thresholds, quality is improved with incremental increases in staffing up to and including these thresholds.

As of Jan. 1, 2003, under Section 941of the 2000 Benefits Improvement and Protection Act (BIPA), all Medicare and Medicaid participating nursing homes are required to post "in a clearly visible place" the on-duty number of RNs, LPNs and CNAs by shift. The National Long Term Care Ombudsman Resource Center has pointed to several shortcomings with this law. It does not require a separate posting for each unit, nor does it require the nursing home to post the number of residents in the nursing home or on each unit at the time the numbers are posted. (http://www.ltcombudsman.org/ombpublic/49_369_3974.cfm)

Although legislation has been introduced in Rhode Island to require nursing staff level reports in hospitals (2004-S2413 by Sen. Roberts), it has not included nursing homes.

1.4. Management/Owner and Professional Responsibility Issues

Responsibility of Governing Body and Administrator

Under federal law, a nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (Social Security Act Title 18 Sec. 1819 and Title 19 Section 1919). State regulations govern the licensing of nursing homes and allow licenses to be issued to an individual owner, operator or lessee, or to the corporate entity responsible for its governance. The license is considered the property of the state and, as such, is loaned to the licensee. In the case of Hillside the licensee was Hillside Health Center Associates, LP which was the real estate company. The operator of the nursing home was Hillside Health Center, LLC. In addition, Hillside had a management contract with Sterling Health Care Management Company, an entity which had a business relationship with Hillside's owners. The Task Force did not have access to the management contract for the nursing home.

State regulations require nursing homes to have an organized governing body or other legal authority responsible for management and control of the operation; maintenance of the facility; and conformity with all federal, state and local rules and regulations.

The governing body or other legal authority is required to provide facilities, personnel and other resources necessary to meet resident and program needs. It also must designate a licensed administrator to establish by-laws or policies to govern the organization of the facility; to establish authority and responsibility; and to identify program goals.

These regulations also require every nursing home to have a full-time, licensed administrator who is directly responsible to the governing body or other legal authority for its management and operation, and to serve as a liaison between the governing body, medical and nursing staff and other professional staff. The administrator is responsible for ensuring that required resident services are available on a regular basis and provided in an appropriate environment in accordance with established policies.

Nursing home administrators are licensed by the state Board of Examiners for Nursing Home Administrators, a seven-member body appointed by the HEALTH director with the Governor's approval (RIGL 5-45). Under state law, nursing home administrators must complete 40 hours of continuing education every two years. Following review and hearing by the Board, the department may suspend or revoke a nursing home administrator's license, or it may reprimand, censure, or discipline a licensee upon proof that the licensee engaged in unprofessional conduct. Unprofessional conduct includes, but is not limited to:

(1) Being unfit or incompetent by reason of negligence, habits, or other causes;
(2) Acting in a manner inconsistent with the health and safety of the patients of the home in which he or she is the administrator; and
(3) Failing to conform to minimal standards of acceptable and prevailing practice of nursing home administration.

The serious care issues and financial problems found at Hillside speak to its management problems. Carol Mancini, the administrator brought in by the court-appointed receiver to manage Hillside when it went into receivership, testified at the Task Force's July 21st public hearing about the extent of the problems she found at Hillside.

Excerpts from testimony of Carol Mancini (Task Force Public Hearing July 21, 2004)

(Note: On March 10, 2004 Ms. Mancini was appointed administrator of Hillside.)
"…we tried to make things better. The one thing we did not have, Lieutenant Governor was time. Time was not on my side. Fifty-four days to the federal survey was not enough time to correct six years of neglect and mistreatment that was going on….Roberta (Hawkins) and I totally were amazed that the families did not really know what was going on…We had to correct the dietary issues, which was too numerous. We would need five hours to go into the dietary issues…Hillside as you know is a very beautiful building. It was totally dysfunctional on the inside. It lacked leadership. It lacked accountability…Nobody wanted to be accountable to anything…It went on way too long before new management was brought in…Certainly I believe everyone in the community knew exactly what was going on, certainly we knew it, other nursing homes, what was going on with the finances at Hillside….I was told that the biggest problem was the union, and what I found was,...it

was not the union sir, it was licensed personnel. The aide would go to them and ask them, and beg them, to please look at a resident, and nothing would happen. They would not get off their butts…They just did not want to be accountable to anyone. So we subsequently fired all of the nurses that were bad… I believe from the beginning, when Hillside started, it never got off the ground properly because it didn't have a seasoned experienced administrator. He had never been an administrator in another facility, and it never got off the ground running right and it just kept going down and down…the turnover was unbelievable. No one was watching the store, no one was watching anything, and when you try to pull that all in, it made it even more difficult to do…the deficiencies…as they stood as a matter of public record went deeper than what was really on that paper, …as you delved into them …the problems went even further, so there was 12 more stacked behind it, …when they filed their plan of corrections,…nowhere did administration go out and sit down with the people on the floors…and explain to them…nobody knew what the plan of correction was or had seen a copy…So, subsequently they hit them with more deficiencies. They did this five times..(What brought Hillside down?) I believe leadership (lack of) and accountability….hopefully when someone like Roberta (Hawkins) is out there for many years, for several years complaining about what was going on at Hillside. Someone needed to listen, and no one was listening…."

The Role of the Medical Director and Attending Physician

Both federal regulations (42CFR483) and state law (RIGL 23-17-10.5) require nursing homes to designate a physician to serve as Medical Director responsible for implementation of resident care policies and the coordination of medical care in the facility. Under state regulation (R23-17-12.1) the Medical Director is also responsible for ensuring completion of employee health screening and immunization requirements. Under state regulation (R23-17-12.2) the nursing home administrator must notify the medical director immediately when certain enforcement orders are issued or actions taken. The administrator is also responsible for providing copies of all statements of deficiencies and related plans of correction to the medical director in a timely fashion. However, HEALTH reports that this policy has not always been followed and, therefore, the department has adopted a new practice of providing copies of survey reports to medical directors.

State regulations also require the medical director to attend the quarterly quality assurance/improvement meetings and this attendance record is reviewed as part of the survey process. HEALTH staff report that the state has a Chapter of the American Medical Directors Association and that HEALTH is in the process of compiling data on state nursing home medical directors to include age, number on nursing homes they serve, educational and training background and any specialty credentials.

Each nursing facility must maintain an active file of all residents' physicians. In the event "Substandard Quality of Care" is found, HEALTH must notify the attending physician of record. To serve this notice, HEALTH uses a form letter provided by CMS which does not specify the care problems involving their resident.

The report to the Governor on Hillside stated that complaints against the physicians involved with Resident #1 were filed with the Board of Medical Licensure and Discipline on Aug. 31, 2004. As state policy prohibits the Task Force from obtaining information on complaints until an official sanction (if any) is imposed, the Task Force does not know which physicians are the subject of any complaints or if the Medical Director is under investigation.

Director of Nursing

State regulations (R23-17-22.2) require nursing homes to have formally organized nursing services under the direction of a full-time Director of Nurses (DON). The DON must be an RN employed full-time and have at least two years experience in nursing supervision or, by training and experience, shall have demonstrated competency in nursing service management. The DON cannot work as DON for any other facility and cannot be the administrator or the assistant administrator of the facility. DONs are responsible for the total nursing service which includes the development, maintenance and evaluation of nursing practice standards; development and periodic revision of nursing policies and procedure manuals; and making recommendations to the facility's administration about the number and categories of nursing personnel and provision of staffing levels required to provide resident care. There is no requirement that the nursing director be experienced in long-term care or geriatric nursing or that she/he obtain any specific continuing education in long term care or geriatric nursing or long term care management. The nursing home is required to report to HEALTH whenever it has a change in the Director of Nurses.

The report to the Governor on Hillside noted that reports were made to the Board of Nurse Registration and Nursing Education for the Director of Nursing. However, the report to the Governor did not provide further detail about these reports and they were not available to the Task Force.

1.5. Promoting System Quality

Quality Assurance and Improvement

The survey and enforcement process are intended to determine if nursing homes comply with the minimal standards deemed necessary to provide quality care. They are but one aspect of the quality picture and must go hand-in-hand with quality improvement programs. Each nursing home is required by federal law to have a Quality Assurance Committee to evaluate and improve care on an ongoing basis (42 USC 1396r). Federal regulations for Quality Assurance Committees are excerpted below: (42CFR483.1(o))

> (1) A facility must maintain a quality assessment and assurance committee consisting of--
> (i) The director of nursing services;
> (ii) A physician designated by the facility; and
> (iii) At least three other members of the facility's staff.
> (2) The quality assessment and assurance committee--
> (i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and
> (ii) Develops and implements appropriate plans of action to correct identified quality deficiencies.

In addition, state regulations (R23-17-10) also require a nursing home to have a quality improvement program.

> 10.6 The governing body shall ensure that there is an effective, ongoing, facility-wide quality improvement program to evaluate the provision of resident care.
>
> 10.7 The organized facility-wide quality improvement program shall be ongoing and shall have a written plan of implementation.
>
> 10.9 The facility shall take and document appropriate remedial action to address problems identified through the quality improvement program. The outcome(s) of the remedial action shall be documented and submitted to the governing body for their consideration.

The Task Force did not have access to any records of Hillside's Quality Assurance (QA) Committee and does not know if the governing body was provided or reviewed its work. However, the gravity of the care issues found with some of Hillside's residents and the fact that Hillside was a "Yo-Yo" nursing home unable to remain in substantial compliance with care standards over time leads the Task Force to conclude that the work of Hillside's QA Committee was ineffective.

Some states have enacted state quality assurance laws that go beyond the federal requirements. One example is Maryland which passed legislation in 2001 mandating nursing facilities establish an effective quality assurance program with the goal of changing the culture within the nursing home from one of living from survey to survey, to one focused on internal quality improvement. Maryland also has a process of "second surveys" in which the first standard annual survey which checks for compliance with standards is followed by a second survey which looks at quality improvement.

> ***Summary of Maryland Quality Assurance Law* (*COMAR 10.07.02.45)***
> Program requirements include the appointment of a qualified assurance manager and creation of a quality assurance (QA) committee that must include at least the director of nursing, the administrator, the medical director, a social worker, dietician, and geriatric nursing assistant. The committee must meet monthly to implement the QA plan and prepare monthly reports for the ombudsman, family council and resident's council. The nursing home's QA plan is submitted to the licensing agency for yearly approval. The QA plan must include procedures for concurrent review and ongoing monitoring of resident status; handling and reporting of patient complaints; procedures for accidents and incidents; and procedures for implementing abuse and neglect regulations (e.g., family notification). The concurrent review consists of daily rounds by a licensed nurse to determine any changes in each resident's physical or mental status. Review of clinical data on any resident with a change in status must include medications, laboratory values, intake and output, skin breakdown, weights, appetite, injuries and any other parameter that may affect the patient's physical or mental status.

Public Reporting and Federal/State Quality Improvement Initiatives

The state has three sources of public reports dealing with nursing home quality. HEALTH maintains a web-based Nursing Home Survey Performance Tool which provides for each nursing home a composite survey score based on five areas as well as the deficiency reports for the last two years. Hillside's score of 68 on this performance tool was the lowest in the state.

NURSING HOME	SURVEY DATE	ADMINISTRATION Max.Score:26	NURSING Max.Score: 22	RESIDENT RIGHTS Max.Score: 18	FOOD SERVICE Max.Score: 8	ENVIRONMENT Max.Score:14	TOTAL Max. Score 88
HILLSIDE HEALTH CENTER PROVIDENCE	10/28/02 11/4/03	21	16	16	4	11	68

The landmark 1998 Rhode Island Health Care Quality Performance and Reporting Program (RIGL 23-17.17 (1-6) - the "Fogarty" law) requires the state to issue quality reports on licensed health care facilities using both clinical and consumer satisfaction measures. To help implement the program, the law mandated a mandatory Steering Committee of which there is a special Nursing Homes Measures Subcommittee.

Following passage of the "Fogarty" law, Rhode Island was one of several states to participate in a pilot CMS-led public reporting program on nursing home quality. To comply with state law, the state created a web-based state based on CMS-required clinical measures. To comply with the requirement to report on satisfaction measures, HEALTH is currently implementing a state-wide nursing home satisfaction reporting program. Public reports in the area of nursing home resident and family satisfaction are anticipated for release in the fall of 2005.

The state website for nursing home quality measures shows Hillside's pressure ulcer rate for high risk residents was 27 as contrasted to a state average of 16; the rate for low risk residents was 3, the same as the state average (reporting period was September, 2003)

The third web-source for nursing home quality information is the CMS site, ***Nursing Home Compare***, which provides information on quality measures; inspection/survey results; and staffing. (http://www.medicare.gov/NHCompare/Home). Due to lag time in the capacity of the state to provide required annual fire safety information to CMS, Rhode Island information on this website has not always been up-to-date. HEALTH has made progress in its efforts to address this.

The Nursing Home Measures Subcommittee for the "Fogarty" law is led by Dr. David Gifford, MD, MPH, Chief Medical Officer, Quality Partners of Rhode Island and Associate Professor of Medicine & Community Health, Brown University, and includes provider, state and advocacy agencies. The Committee has worked closely with QPRI to help identify issues in need of quality improvements and to implement training programs for the state's nursing homes. Over the past several years, QPRI has provided education to nursing homes in the areas of pressure ulcers, pain management and infections. Nursing homes participate in the training on a voluntary basis. Nursing homes that have participated in the training programs have shown improved scores in associated clinical areas.

Members of the Nursing Home Measures Subcommittee took on the task of serving as a Statewide Steering Committee for Quality Improvement. This group is in the process of developing programs to "reward" nursing homes for best practices and excellence in care.

Performance Incentives

Some states have initiated programs to improve quality using reimbursement incentives or by using civil monetary penalty (CMP) funds collected by CMS and turned over to the state.

In 2002, Iowa began using a Medicaid reimbursement methodology that includes a provision that up to 3% of a nursing facility's Medicaid rate will be based on facility performance. Called the Accountability Measures program, providers will automatically receive 97% of their regular Medicaid rate, but then must earn points to receive the remaining 3%. There are 10 ways the provider can receive points, including regulatory compliance; greater number of nursing hours per day per resident; low staff turnover; low administrative costs; and cooperation with the LTCOP volunteer program called the Resident Advocate Committee (RAC) program. If a provider works with the RAC to resolve 60% or more of the concerns identified by the committee or implements a committee's suggestions for improvement, the facility receives a point, which counts towards additional Medicaid reimbursement.

In 2004, West Virginia started a new process, using the civil money penalty funds to improve recurrent deficient practice in Medicaid certified nursing facilities in West Virginia. This process allows eligible facilities to receive matching funds in order to implement facility specific quality improvement projects. Mississippi Medicaid also provides grants to nursing facilities for quality improvement efforts through the use of civil money penalties.

Federal Medicaid law includes provisions to allow financial incentives for high quality care.

> (42USC1396r)SEC 1919 (h)(2)(F). INCENTIVES FOR HIGH QUALITY CARE.—In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this title. For purposes of section 1903(a)(7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.

In 2004, the LTCCC prepared state legislation (S2797 by Sen. Elizabeth Roberts and H7613 by Rep. Thomas Slater) that would have created the Long Term Care Improvement Fund. This fund would have used civil monetary penalties assessed against long term care facilities for nursing home quality improvement. The legislation did not pass.

Industry-led Quality Improvement Initiatives

Concerned about the recent events of poor quality reported in a few Rhode Island nursing homes, the nursing home industry, as represented by the RI Association of Facilities Services for the Aging, the RI Chapter of the American College of Health Care Administrators and the RI Health Care Association have proposed a six-point program, "***Achieving Higher Quality in Rhode Island Nursing Homes".*** The initiative, to be implemented in collaboration with Quality Partners of RI and Brown University over the next year, includes the following.

1. **Improve workforce stability** by significantly reducing staff turnover and improving staff retention;
2. **Implement state-wide program to prevent new facility acquired stage III or IV** pressure ulcers by implementing evidence based practices to prevent pressure ulcers;
3. **Implement a nurse manager training program** (for Directors of Nursing and unit Managers) to address workplace practices that ensure consistent and reliable implementation of effective care practices and help to stabilize the workforce;
4. **Collect and report family and resident satisfaction publicly** for each nursing home in RI using the same questionnaire in order to allow consumers to compare information between nursing homes;
5. **Create a semi-annual forum for nursing homes to share best practices** and discuss barriers and challenges with each other; and
6. **Provide the public with information on high performing nursing homes** that achieve objective benchmarks of quality.

Part 2. FINDINGS AND RECOMMENDATIONS

2.1. The Health Services Council

Finding: Owner equity provisions for Hillside recommended by the HSC were not consistent with its policy. The basis for equity requirements is to (1) demonstrate a commitment of the applicant to a project, and (2) to reduce the cost of the project to payers. Prior experience in varying the 20 percent equity contribution had proven to be problematic at Meadow Glen nursing home which closed in March of 1994 due to financial problems and serious patient care issues. Although nothing was found on the record to disqualify a change of ownership to the Hillside applicant, Antonio L. Giordano, it was known the applicant had been banned by HUD for a period of time in the past and that there had been issues relative to payment of loans in the past.
Recommendation 1: The General Assembly should consider incorporating equity standards for nursing homes into state statute and require that any variance from these provisions be explicitly justified in writing or that alternate arrangements such as escrow accounts (under the control of HEALTH) be made a condition of approval. An alternative would be for the legislature to mandate that the HEALTH Director promulgate regulations regarding equity standards for nursing homes.

Finding: The Hillside proposal projected that about two-thirds of the residents would be reimbursed under the state Medicaid program so the issue of affordability for the state was very significant. State law and HEALTH regulations do not include any specific standards for determining affordability or for giving any special consideration to a proposal that will rely to a great extent on state funding. During review, the State Budget Officer and the representative of the Department of Human Services (DHS) found that Hillside's initial Certificate of Need (CON) proposal for the 236-bed renovation was not affordable for the state. Despite this, the full Health Services Council determined that the project met the state's public need and affordability requirements.
Recommendation 2: The General Assembly should review the standards for determining public need and affordability of nursing homes and mixed-use, long term care facilities and consider whether the standards should be subject to more rigorous criteria.

Finding: The initial Hillside application included a 39-bed assisted living residence in an annex building in addition to 236 nursing home beds. During the Hillside application review, DHS staff recommended that costs associated with the assisted living annex *"be included in the financial analysis since the financing of the entire project has to be understood to make a judgement on its viability"*. Hillside stated that the assisted living facility was completely separate from the nursing home and would have no shared costs and a separate mortgage. When the Hillside proposal was modified to reduce the number of nursing home beds and increase its non-nursing home residential capacity, the need to look at the project in its entirety in terms of its financial viability became important. However, there was no legal basis for the HSC to conduct a review for the new proposal for a mixed-use project as the nursing home renovations component no longer fell within the CON capital requirements.
Recommendation 3: The legislature should consider amending the Certificate of Need (CON) law to require that mixed-use facilities that include both assisted living and nursing home components be examined and analyzed by the Health Services Council in the aggregate.

Finding: The Task Force found questions relating to the membership and terms for some appointments of the Health Services Council. The law does not specify that any of the members have demonstrated experience in either health care or financing nor does it set prescribed terms for the legislatively appointed members. Membership attendance was also found to be a problem in the past. Adequacy of staff resources, notably with regard to ability to review and analyze the finances of project applications is also a concern.
Recommendation 4: The General Assembly should revise the statute creating the Health Services Council and its provisions for appointments of members and requirements for continued service. All members terms should be defined in statute and membership should include consumer representatives and persons with experience in areas such as health care and finance.
Recommendation 5: HEALTH should review staff capacity to assist the HSC and, if necessary, develop the means to provide the expert financial and clinical analysis required to appropriately review projects. This could be done by using staff expertise at HEALTH or other agencies or the engagement of consultants on an as-needed basis and paid for through applicant fees as appropriate.

2.2. Financing Issues

HUD
Finding: The Task Force questions the basis on which the initial approval for mortgage insurance for the Hillside project was made by the HUD local field office. The assumptions on which HUD determined the need for these beds is clearly an issue. In addition, the project analysis estimated that 26 percent of Hillside's gross income would be generated from the non-nursing home components. These projections were very optimistic and did not materialize. Nor did the projected 70 percent Medicaid payer mix for the nursing home bed component. Data provided by DHS shows the Hillside nursing home payer mix for 2000, its first full year of operation, at 75.5 percent Medicaid. This Medicaid payer mix gradually increased to 80 percent in 2003. Moreover, total occupancy at Hillside in its last two years was only 86 and 87 percent.

Recommendation 6: Request that Congress review HUD criteria for assessing risk, including the determination of need for nursing home beds and assisted living residences.

Finding: A study of HUD's "232" nursing home program conducted by HUD's Office of Inspector General (Audit Report #2002-KC-0002) found that HUD did not have adequate controls in place to ensure violations of its regulatory agreements were being identified and that this had contributed to the high number of mortgage defaults and assignments. The report found that management did not properly assess and identify risks and implement proper controls to protect HUD's interests in its nursing home portfolio. It also reported that leased nursing homes are not required to submit annual audited financial statements to HUD's national Real Estate Assessment Center (REAC) and that HUD is not able to use the system's financial and compliance checks to identify and follow-up on deficiencies. This audit report made a number of recommendations to strengthen program oversight.
Recommendation 7: Request that the state's Congressional delegation determine the status of implementation of recommendations in the 2002 OIG report on the HUD nursing home program and that they support a requirement that audited financial statements be submitted to the HUD's national REAC from both nursing home owners and lessees. In addition, the Congressional delegation should work to obtain authority for HUD to share information on a nursing home's financial status with state nursing home licensing agencies. This would give the licensing agency a means to detect early on financial problems that may be signaling pending insolvency or care issues.

Finding: Local HUD staff does not currently receive survey reports on HUD-financed nursing homes. A HUD staff review of nursing home survey reports noting serious care or environmental issues could trigger communication between HUD staff and nursing home owners/lessees for the purpose of addressing these deficiencies.
Recommendation 8: HUD should provide HEALTH's Office of Facilities Regulation with a list of HUD-financed nursing homes and HEALTH should provide local HUD staff with copies of survey reports for nursing homes not in substantial compliance. Note: To start this practice, local HUD staff provided HEALTH with a list of HUD-financed nursing homes in the state via email on Nov. 4, 2004.

Finding: The Task Force was left with many unanswered questions regarding HUD's role in financing Hillside, the relationship between the company holding the Hillside mortgage and Hillside's owners, and HUD's ongoing accountability for oversight of Hillside's financial integrity. It assumes that the HUD local office was aware of the increasing amount of debt as submission of annual financial statements to that office was required. However, the Task Force could not ascertain if HUD took any corrective action or made recommendations to the management to address the financial issues. The Task Force attempted to determine if a federal audit of Hillside is underway or had been completed. A letter to Chairman Fogarty dated Nov. 3, 2004 from Heath Wolfe, Acting Region One Inspector General for Audit stated "*Please be advised that the Office of Inspector General for Audit for the U.S. Department of Housing and Urban Development (HUD) initiated an audit of the Hillside Health Center in April 2004. We discontinued our audit in July 2004. HUD's Office of Inspector General continues to be involved with Hillside's issues, but we are unable to elaborate on our involvement at this time."*
Recommendation 9: Request that the state's Congressional delegation determine the status of any HUD investigation. In a letter dated October 7th, Chairman Fogarty asked the members of

the state's Congressional delegation to look into HUD's involvement with Hillside. In response, a letter dated October 18th was sent to HUD Assistant Secretary for Congressional Affairs, Stephen Nesmith, signed by all the state's Congressional members detailing the request from Chairman Fogarty.

State Financing and Financial Oversight

Finding: The ability to provide quality care is directly related to availability of resources. No state agency is currently responsible for reviewing the financial health of nursing homes paid for with government funds to detect which homes might be in financial trouble that may lead to poor performance, or ultimately, insolvency. This is a major gap in the system that needs to be addressed. There is no requirement to submit financial statements with cost reports to DHS. Therefore, DHS states it is unable to get a true picture of a nursing home's finances. HEALTH does have the statutory duty to adopt regulations requiring that nursing homes report uniform data, including data on a nursing home's financial condition, on a periodic basis, but they have not done so to date and there is no requirement that this data be reviewed as part of the survey process. If the data were to show financial mismanagement or potential for financial failure, current state law regarding placement of a nursing home in receivership (RIGL 23-17.11) does not provide for an intermediate step to permit HEALTH to ask the Superior Court to appoint an expert to review a nursing home's financial status and problems to determine if a financial plan of correction can save the nursing home prior to taking the step of involuntary receivership.

Recommendation 10: Prepare legislation that would require all certified nursing homes submit financial statements or additional selected financial information to DHS with their annual cost reports. DHS will review this financial information and, based on selected financial triggers, put a nursing home on a "financial alert" whereby HEALTH regulatory staff would be notified and be required to monitor these nursing homes on a more frequent basis to ensure that care standards are not being compromised due to financial problems. The state long-term care ombudsman would also receive notice of the nursing homes put on "financial alert."

Recommendation 11: HEALTH should develop data standards on finances that will be submitted by nursing homes to HEALTH as required by law. These financial data reports can be submitted as part of the annual re-licensing process and shared with DHS.

Recommendation 12: Develop a set of selected financial conditions that indicate a facility is in financial trouble and which the facility must report to DHS and HEALTH and which causes the facility to be put on a "financial alert" list for closer monitoring of care by HEALTH and the long-term care ombudsman and review of financial issues by DHS .

Recommendation 13: Provide HUD local office staff a list of HUD-financed nursing homes placed on the state's nursing home "financial alert" list to allow HUD to monitor them more closely and work with the parties and lenders to address financial issues.

Recommendation 14: Amend state law 23-17.11 to give the HEALTH Director authority to petition Superior Court to have a "crisis" manager or consultant review a nursing home's finances and operations when there is a reasonable belief that financial mismanagement has occurred or insolvency is imminent and to make recommendations for a plan of financial recovery or to recommend that involuntary receivership should be pursued.

2.3. Licensing Standards and Enforcement

Finding: To a great extent the survey and enforcement process is dictated by federal provisions. It is a system which relies on punitive actions to force compliance and has been criticized in major studies for its great variation in survey findings across states. None of these studies has included Rhode Island. The regional CMS office does conduct performance evaluations of state survey activities that includes a limited number of observational and comparative surveys in each state. In 2002, RI did not meet federal performance standard #3 criteria relating to unjustified discrepancy rate for disagreements with deficiencies between the regional office and the state. Following this, the regional office report states it consulted with the state and conducted on-site trainings. The following year, the state met the evaluation criteria for this standard. The Task Force did not conduct an internal review of the survey process as part of its work, so it can not comment on the performance of the office
Recommendation 15: At the request of legislative leaders, the state Auditor General has begun an audit of the Office of Facilities Regulation. To ensure confidence that the survey process is being applied consistently and fairly in the state, the Task Force recommends the audit include a review of the application of federal survey rules and guidance on scope and severity and state survey requirements to determine if they are being applied objectively and in a standardized manner.

Finding: On many occasions during Hillside's history, enforcement remedies recommended by the state were reduced by the regional CMS office. Some states have codified the federal nursing home standards (or major portions of them) and developed corresponding state enforcement sanctions that give them more control of the enforcement process. Rhode Island has incorporated some portions of the federal code into state statute or into state regulation. Legislation was introduced in 1998 to codify federal standards into state law in the event Congress repealed federal standards as was under discussion at that time. The legislation did not become law (98-S2308 by (former) Senator Charles J. Fogarty).
Recommendation 16: The LTCCC should review the need for, and advisability of, legislation to incorporate federal nursing home standards (or appropriate portions of them) into state statute and to provide HEALTH with additional enforcement powers specific to these standards so they do not have to rely on the federal government.

Finding: Prior to its first finding of "Substandard Quality of Care" in December 2003, there was ample warning that Hillside was a poor performer and steps could have been taken to avoid the continued and extensive care issues and its ultimate closure. However, as currently implemented by HEALTH the enforcement system fails to identify early on poor performing nursing homes in need of more frequent monitoring visits to protect resident safety and promote quality. The current benchmark used by HEALTH for determining "Substandard Care" (the federal definition) is set too high to be a useful tool in identifying poor performers that should be targeted for more frequent monitoring or for quality consultations.
Recommendation 17: Revise RIGL 23-17-12 to provide for increased monitoring of nursing homes with poor compliance performance but which do not meet the federal definition of "Substandard Quality of Care". One option is to require a second visit for nursing homes that have a deficiency related to "Actual Harm". In addition, HEALTH should review 23-1-12 and adopt regulations as mandated to require criteria for determining frequency of surveys using patient acuity; quality indicators; a facility's past compliance; and changes in management staff (administrator and director of nurses).

Finding: On December 31st, following the Dec.19, 2003 survey (revisit) during which the facility was cited for "Substandard Quality of Care" (in relation to pressure ulcers), the HEALTH Director stopped admissions to Hillside. HEALTH also started state monitoring on Jan. 4, 2004. However, there were additional legal tools that could have been used that may have prevented Hillside's closure. Section 6 of RIGL 23-17.11 (THE EMERGENCY SKILLED NURSING AND INTERMEDIATE CARE FACILITIES ACT) grants authority to the HEALTH Director to petition Superior Court for the appointment of a receiver in the event of mismanagement. When first asked if using this law had been considered, the HEALTH Director said the department did not think it applicable as they interpreted it as something to be used to close a facility (Task Force meeting of June 23rd). However, at an October 14th meeting of the Task Force a HEALTH Associate Director, stated that the department had misinterpreted that statute as only useful in a closure and they understood now that the statute does provide the Director with the ability to ask the Attorney General to proceed to court to appoint a receiver in order to intervene to prevent failures. This position was confirmed in a letter to Chairman Fogarty from Director Nolan dated November 1, 2004. The Task Force agrees that the record of poor quality combined with indicators of Hillside's financial instability presented a strong case on which HEALTH could have requested the Attorney General file for receivership with the intent of preserving the facility. Moreover, it was at the time immediately following the December 19th survey that imposition of a temporary manager or crisis management team by a court-ordered receiver may have prevented Hillside's ultimate closure. This would have given new management four months to come into compliance before the 180-day termination date imposed by CMS would take effect. It would have also provided time to determine if a plan of financial recovery was feasible. However, a receiver was not appointed until two months later, on March 4th, following a voluntary petition by Hillside. This left very little time for the new administrator appointed by the receiver to make the changes necessary to bring Hillside into compliance. The other option that was available to the department was to recommend to CMS that a temporary manager be imposed as a federal sanction following the February 13th finding of "Immediate Jeopardy". State law also provides additional authority to the HEALTH Director to enforce nursing home standards and/or to protect residents. RIGL 23-1-21 - Immediate compliance order – gives the HEALTH director authority to take immediate action to protect the health, welfare, or safety of the public or any member of the public by issuing an immediate compliance order, without prior notice of violation or hearing. Also, RIGL 23-17-8.1 appears to give the HEALTH director broad powers by empowering the director "to take any other corrective action necessary to secure compliance with the requirements established under this chapter".

Recommendation 18: Revise the language in 23-17.11 to expand the Director's ability to use this law to prevent a nursing home's failure for financial mismanagement or other reasons and to allow the Director to go directly to Superior Court. The law should also allow HEALTH to ask the Court to take the interim step of appointing a "crisis management team or crisis consultant" that could analyze the situation at the nursing home. The team or consultant would have authority to take action to remedy problems without resorting to receivership. The state's nursing home professionals should assist in identifying professionals willing to provide such crisis consultant or crisis management services.

Finding: The September 17th report to the Governor, ***"Review of Department of Health's Response to the Quality of Care at Hillside Health Center"***, included an extensive review of

the care received by Resident #1 and HEALTH's survey and enforcement actions in regard to Hillside and in particular, Resident #1. The Task Force did not have access to the detailed records made available to the investigators involved with the report to the Governor. However, based on its own review of available records and review of the Report to the Governor, the Task Force agrees with the Report's conclusion that earlier and more aggressive action should have been taken to ensure that Resident #1 consistently received the care she needed. However, based on statements made by HEALTH staff, it is not clear if current law empowers HEALTH with the duty or responsibility to protect the safety of individual residents.

Recommendation 19: Review state law to determine if HEALTH has sufficient and clear authority to take action to protect individual nursing home resident safety and to ensure they receive necessary care. Revise state law, as necessary and appropriate, to clarify HEALTH's role in protecting health and safety of individual nursing home residents.

Finding: While HEALTH is involved in a number of quality improvement programs it currently has no formal mechanism to offer or impose technical assistance and consultation to nursing homes found to be seriously deficient in meeting quality care standards or with a history of poor performance. Several states have developed quality improvement programs or consultation programs to assist nursing homes in meeting standards or to improve care. Some are performed by state staff within the survey office, others are completely separate. Examples include Maryland which authorizes the appointment of an independent state monitor paid for by the nursing home as an intermediate sanction when a nursing home is not in compliance (Md. Code, Title 19-1405. Independent State monitor) and Michigan's Collaborative Remediation project which places experienced consultant-remediators into troubled facilities as an alternative to other enforcement actions ("*Predicting and Preventing Nursing Home "Performance Closures" in Michigan: Why Regulators May Not Have All the Tools They Need",* Alison E. Hirschel, July 2002). Research has shown the positive impact of these types of programs. Another option is to use rapid-response or crisis management teams composed of experienced long term care experts that can visit a poor performing nursing home and offer guidance in establishing system changes needed to come into and sustain compliance. In October of this year, the HEALTH director did order a RI nursing home to engage a quality improvement consultant. HEALTH staff reports they could do this because in granting the license, certain conditions of approval and an escrow account had been set up to be used in the event of problems. It is not clear if HEALTH could issue similar orders in the absence of such licensing conditions.

Recommendation 20: The LTCCC should work with key stakeholders to prepare legislation to create a quality consultation and/or monitoring program to be used with poor performing nursing homes based on specific survey findings or other indicators of poor performance.

Recommendation 21: Review RIGL 23-1-21 and RIGL 23-17.8-1 to determine if currently HEALTH has the authority to employ other legal options such as the appointment of temporary managers, consultants, clinical/quality advisors, or crisis management/rapid response teams. If this is not the case, prepare legislation to give HEALTH these specific state legal tools in appropriate circumstances.

Finding: Multiple complaint and incident reporting requirements are mandated under several separate state and federal laws or policies. In some instances, providers are reporting to multiple entities. Consumers and families are also faced with identifying the appropriate agency and process for making a complaint and whom to call or notify about the complaint.

The various entities to which complaints get reported may not all be coordinating with each other and in agreement on their roles and issues relating to information sharing and confidentially. State law (RIGL 42-66.7-13) requiring the establishment of an interagency agreement to ensure a cooperative effort in meeting the needs of the residents of long term care facilities has not been fulfilled.

Recommendation 22: As part of the Auditor General's audit, the legislature should specifically request that a review of the various complaint reporting requirements be conducted to determine existing opportunities for greater coordination among agencies and any efficiencies that could be obtained in the complaint reporting and investigation process without diminishing resident's rights or reducing the resident safety and protections afforded through the complaint process.

Recommendation 23: The administration should initiate action to establish the interagency agreement on interdepartmental cooperation regarding long term care residents as required under state law.

Finding: Issues regarding the resource needs of the Office of Facilities Regulation were found as system issues. One issue is the ability of staff to investigate complaints within the mandated timeframes. Another issue is to identify staff needs associated with recommended increases in the frequency of surveys. A final concern was that no one on staff had experience in nursing home administration or finances. This was noted as being important since poor managerial control was a major factor in Hillside's failure. HEALTH has put forward a request for supplemental funds to the administration for FY2005 to support six additional staff for facilities regulation.

Recommendation 24: The audit being conducted by the State Auditor General should review the ability of the Office of Facility Regulation's staff to perform all its mandated functions and its capacity to provide oversight in the matters of nursing home administration and financial adequacy. As part of this review it should identify existing state resources available to provide HEALTH with consultation or expertise in such areas as financial oversight or review. The Task Force supports the urgent need for adequate staff and recommends that the administration carefully review HEALTHs supplemental funding request for the current fiscal year. The findings of the auditor general regarding resource needs should be reviewed as part of the state FY2006 annual budget process.

Finding: Communication with family members or resident representatives is a vital aspect of quality care and quality improvement. For many residents, family members are the primary advocates to point out problems or to alert staff to changes in conditions. However, at present there is no requirement to notify residents or family members (or guardians) when a nursing home is found to be providing substandard quality of care or when a nursing home is put on notice that it may be terminated from the Medicare program if it does not come into compliance. Neither is there a requirement to notify individual family members when a resident is found to be in "Immediate Jeopardy", when "Actual Harm" has occurred or when state monitoring is imposed in relation to a certain resident. These are serious gaps in the communication process.

Recommendation 25: Amend state law to require that HEALTH notify residents (when competent) and their family members or legal representatives when a nursing home is found to have "Substandard Quality of Care"; when it is put on state monitoring; or when a sanction involving "No Opportunity to Correct" is imposed. This notice should also be provided in the event of certain state-ordered compliance orders such as denial of admissions. The state

LTCO, DHS and members of the nursing home profession should be involved with HEALTH in developing and implementing the process used for this notice requirement. The law should also require notification of family (or the legal representative) of any residents found to be in "Immediate Jeopardy" or with "Actual Harm". In the event a nursing home resident has no family or legal representative, the LTCO should be the person to be notified.

Finding: Resident/family councils have potential to play a vital role in advocating for quality care and improvement. While federal law provides some support for resident/family councils, these can be enhanced at the state level to provide specific timeframes for nursing homes to respond to issues brought up by the council and for resident/family council representatives to provide input to the survey team both during the survey and revisit to determine compliance.
Recommendation 26: The LTCCC will review state laws regarding resident/family councils and prepare legislation to define the role of resident/family councils and the responsibility of the nursing home and LTCO to provide support to them.

Finding: Nursing homes must provide information to residents upon admission and post information on resident rights, grievance and complaint filings, and advocacy phone numbers. There are a number of sources that provide written information in these areas that would be helpful to residents and their families, but no standardized materials have been developed for use statewide. Moreover, there is no ongoing process for information, exchanges among representatives of resident/family councils or for them to come together to discuss common concerns regarding quality.
Recommendation 27: The LTCO should work with appropriate partners, including the nursing home profession, to develop a standardized set of information for residents and families on nursing home grievance procedures; complaints reporting; and resident rights. This information will supplement the information provided as required by individual nursing homes. The LTCCC will advocate for resources for the Alliance for Better Long Term Care to allow for creation of a website to serve as an information exchange for state resident/family councils and to support and facilitate the establishment of resident/family councils.

Finding: Currently, there are no federal or Rhode Island standards for staffing ratios for direct-care staff in nursing homes and there is no reliable Rhode Island data to even determine the level of direct-care nursing staff in the state's nursing homes. Some states have adopted nurse staffing ratios for nursing homes. Congressionally –mandated research published in 2001 shows a clear relationship between direct nursing care staffing levels and the ability to provide quality nursing home care and/or good resident outcomes. Although the research shows that above a certain threshold additional nurse staffing results in no significant benefit with respect to quality, it was clear that below a critical ratio of nurses to residents, residents of nursing homes are at substantially increased risk of quality problems.
Recommendation 28: The issue of the development of state standards for direct-care staff in nursing homes should be reviewed. The review should consider available research on the relationship of nurse staffing levels and quality outcomes; methods for recognizing variations in resident need; and the projected impact on cost and workforce availability. Also, to obtain reliable data on nurse staffing in nursing homes on an ongoing basis, state law should be revised to require that nursing homes systematically report on the levels of actual direct nursing staff and the use of "pool" nurses to meet staffing needs.

2.4. Management/Owner and Professional Responsibility

Finding: The state Long Term Care Ombudsman filed formal complaints regarding the incompetence of Hillside's nursing home administrator as early as 2001 and again in February 2004. Records provided by HEALTH show that in January 2002, HEALTH and the state Board of Examiners for Nursing Home Administrators completed an investigation into a complaint regarding the administrator's professional conduct and concluded there was insufficient evidence to establish grounds for disciplinary action. In January 2003 HEALTH issued a letter dismissing a complaint of unprofessional conduct against the administrator after review and consultation with the Board of Examiners in Nursing Home Administrators. Based on comments made to the Task Force staff in an interview with Hillside's court-appointed receiver, Carol Mancini, the problems with the administrator's ineffectiveness appear to have been well-known within the long term care community. Under federal law, the state Board of Examiners for Nursing Home Administrators must be notified when "Substandard Quality of Care" is found in a nursing home survey. Hillside was cited for "Substandard Quality of Care" on its Dec.19, 2003 survey. However, according to the Board Chairman, the Board was not notified of this. The Board Chairman also related to the Task Force that on several occasions there has been a gap of as long as six months before the Board received information on surveys as required by law. Despite Hillside's continued and serious non-compliance, the owner/operator did not replace the administrator and HEALTH never considered ordering that a temporary manager replace the administrator to try to correct the widespread quality of care issues. Ultimately, it took placing Hillside into receivership in March 2004 before a new administrator was appointed. HEALTH did order the permanent revocation of both the administrator's nursing home and assisted living license effective July 29th. This order was reviewed and approved by the Board.

Recommendation 29: Revise state law to authorize the state Board of Examiners for Nursing Home Administrators to take pro-active steps to review and assess a nursing home administrator's competence when a nursing home has a demonstrated record of continued and serious non-compliant issues. Also, empower the board to take action to either put the administrator's license on probationary status or to force appropriate remedial training or continuing education.

Recommendation 30: Revise state law to require that the Board of Examiners for Nursing Home Administrators be provided copies of surveys citing "Substandard Quality of Care" when they are mailed to the nursing home.

Finding: State law makes it difficult to establish managerial and financial accountability for Hillside's operations. Hillside had one entity as its operator while another entity held the license and owned the property. In addition, Hillside was under a management contract with Sterling Health Care Management Company which received significant fees for its services. The Task Force did not have access to a copy of the management contract to determine what responsibilities were outlined and how they related to the duties and controlling authority of the administrator. The state reported it has no requirements that nursing home management companies disclose information about their responsibilities, areas of control or capabilities. This lack of information, coupled with Hillside's corporate arrangements, make it difficult to properly assign accountability for management failures.

Recommendation 31: The General Assembly should consider amending state law to require that nursing homes file with state regulators copies of management contracts with management companies as part of the licensing application and re-licensure process in order to establish who is in control and making decisions. It should also review annual nursing home re-licensing requirements and consider a new system which could put a licensee on probationary or provisional status if it were found to have substantial non-compliance issues. Consideration should also be given to authorizing civil penalties for significant non-compliance to be imposed on persons who control operations.

Findings: Although the medical director is responsible for resident care policies, there is little accountability by the medical director when poor care among residents is found to be problematic. Current provisions do not require the medical director be interviewed as part of the survey protocol or participate in developing or implementing any required plans of correction. Until recently medical directors were not routinely informed of deficiencies and care issues found during the survey process or of subsequent enforcement actions.
Recommendation 32: Amend state law to require that (1) HEALTH provide medical directors with copies of survey reports when they are initially mailed to the nursing home; (2) the medical director be invited to participate in survey exit interviews whenever a preliminary finding of "Actual Harm" or "Substandard Quality of Care" is made; and (3) the medical director participate in and approve all plans of corrections filed for surveys in which serious quality of care issues are found.
Recommendation 33: Require that contracts with the medical director include standard language that details state and federal requirements for medical directors.

Finding: Physicians are notified by HEALTH only when there has been a finding of "Substandard Quality of Care" in the nursing home and this notice does not indicate the specific nature of the care problems or if their patient is involved. It is important to note that a finding of "Actual Harm" may not constitute "Substandard Quality of Care". So physicians may not be notified when "Actual Harm" occurs that does not meet "Substandard Quality of Care" criteria. As residents are only required to be seen by a physician every 90 days (or if a change in condition occurs), the attending physician may not be aware that a resident has experienced "Actual Harm" or be at "Risk for Actual Harm" unless notified by the nursing home.
Recommendation 34: Require that nursing homes notify attending physicians whenever an individual resident is determined at the time of the survey to be at "Actual Harm" or "Potential for Actual Harm". This notice should include specific details on the nature of the findings.

Finding: A Director of Nurses (DON) is responsible for the nursing home's total nursing services. There are requirements that the DON have experience in nursing management, but none relating to long-term care or geriatric nursing. According to reports from the LTCO, Hillside had at least five nursing directors over the years, including three in the last eight months raising serious concerns about the continuity of nursing leadership. State regulations require that a nursing home notify HEALTH whenever there is a change of administrator or in the Director of Nursing position.

Recommendation 35: The LTCCC should work with provider and professional organizations to identify current requirements regarding geriatric nursing in state nurse education programs and opportunities to enhance the curriculum. It should also examine the feasibility of requiring specific continuing education units in long-term care and/or geriatric nursing for licensed nurses in supervisory positions in these facilities. These units should also be looked at as part of the new overall state mandatory continuing education program for licensed nurses and the state should promote opportunities for long-term care nurses to access such programs.
Recommendation 36: HEALTH should consider that frequent changes in the Director of Nursing position is a trigger for more frequent monitoring of a nursing home.

2.5. Promoting System Quality

Finding: Quality improvement programs, including those that provide technical assistance to nursing homes, and those requiring strong nursing home quality assurance programs, have been shown to be effective in improving and sustaining quality. Resources are available in the state to assist nursing homes in addressing quality issues by offering technical assistance or training on a voluntary basis. These include Quality Partners of RI, state provider and professional organizations and our academic institutions.
Recommendation 37: The LTCCC will prepare state legislation to strengthen nursing home quality improvement requirements.
Recommendation 38. The LTCCC will create a quality subcommittee to periodically review state nursing home survey reports to identify care issues and problems occurring on a repeated or system-wide basis. This information will be shared with Quality Partners of RI and providers to assist in selecting targeted areas for training and education that will improve statewide quality.

Finding: Issues regarding the timeliness and user-friendliness of HEALTH's website for nursing home information and reporting on quality measures and survey results are a concern. HEALTH has worked to address the timeliness issue. However, the fact that several different types and formats for reports are presented may be confusing to the public.
Recommendation 39: HEALTH should review the content and presentation of its web-based nursing home reports to determine if they meet consumer information needs. This review should be done in collaboration with the LTCO and DEA and include consumer input. The statewide Steering Committee for Nursing Home Quality Improvement could also assist with this task.

Finding: Mechanisms exist in some states and through Medicaid law to provide funds for quality improvement programs, either by using civil monetary penalty funds or creating Medicaid quality incentive payments. Legislation submitted in 2004 in Rhode Island to establish a Long-Term-Care Improvement Fund using these funds was introduced but failed to pass.
Recommendation 40: Reintroduce legislation in 2005 to create a state Long-Term-Care Improvement Fund with monies from civil monetary penalties.

Recommendation 41: The LTCCC should work to develop a state Medicaid nursing home quality incentive payment program.

Finding: The state nursing home industry, as represented by the RI Association of Facilities Services for the Aging, the RI Chapter of the American College of Health Care Administrators and the RI Health Care Association, has proposed a six-point plan to achieve higher quality in RI nursing homes. This plan is to be implemented in collaboration with Quality Partners of RI and Brown University over the next year and includes efforts to improve workforce stability; reduce pressure ulcers; train nurse managers; report on nursing home consumer satisfaction; create forums to share best practices; and provide public information on high performing nursing homes.

Recommendation 42: The LTCCC should **s**upport this initiative and promote appropriate evaluation, including data collection methods, to measure improvements in quality and/or adoption of best practices that result from the implementing components of the initiative.

Appendix A

Long-Term Care Coordinating Council
Task Force on Nursing Facility Closures

Meeting Schedule

Meeting 1. June 23, 2004 – 10:00 a.m. – Room 313, State House
Overview of State laws, administrative regulations and resources for nursing facility licensing and surveys – Dr. Patricia Nolan, HEALTH Director and HEALTH staff

Meeting 2. June 30, 2004 – 10:00 a.m. – Room 313, State House
Chronology of Hillside Health Center Licensure, Survey and Enforcement History
- Department of Health Staff
  (Dr. Patricia Nolan, John Donahue, Don Williams, Ray Rusin)
- CMS Regional Office Staff (Richard Shaw)

Meeting 3. July 21, 2004 – 5:00 p.m. – HEALTH Auditorium
Public Hearing for Comments from Family members, former and current employees, other interested parties

Meeting 4. August 18, 2004 - 10:00 a.m. – Room 313, State House
Role of RI Department of Human Services/Medicaid agency in Nursing Facility Financing and Financial Oversight –
Mr. John Young, Associate Director,
Division of Health Care Quality and Purchasing,
RI Department of Human Services

Meeting 5. October 1, 2004 - 11:00 a.m. – Room 313, State House
1. The Older Americans Act and the Long Term Care Ombudsman Program
   Corinne Russo, Director, RI Department of Elderly Affairs

2. The Alliance for Better Long Term Care – State Ombudsman Program
   Roberta Hawkins, Executive Director, Alliance for Better Long Term Care
3. The Role of the Medical Director in Nursing Facilities
   Dr. David Gifford, Chief Medical Officer, Quality Partners of RI

Meeting 6. October 14, 2004 - 1:00 p.m. – Room 313, State House

1. Dr. Robert Quigley, Chairman, RI Health Services Council
2. Attorney General's Role in Nursing Home Abuse, Neglect & Fraud
   Cindy Soccio, Assistant Attorney General, Director, Medicaid Fraud Control Unit
   Judy Davis, Special Assistant Attorney General Deputy Director, Director, Medicaid Fraud Control Unit
3. RI Department of Health Staff
   A. Review of DOH Complaint Investigation Process
   B. Review of Scope and Severity Protocols and State Operations Manual Provisions for Temporary Management
   C. State & Federal requirements relating to staffing and reporting on staffing levels

Work Sessions for Report Development

October 28, 2004
November 1, 2004
November 10, 2004

Appendix B
HILLSIDE/JEWISH HOME CHRONOLOGY
(submitted to Task Force on June 30, 2004 by RI HEALTH)

Phase I Initial Change in Effective (CEC) Review

June 1993 - Jewish Home for the Aged of Rhode Island (JHARI) sends initial Closure Plan notification to the Department of Health (DOH) originally scheduled for 15 September 1993 but subsequently amended to 31 October 1993.

15 September 1993 - JHARI enters into an agreement until 31 October 1993 with Health Management Services for physical operation of the facility. JHARI had 21 patients remaining at the home at that time

18 October 1993 JHARI enters into a Purchase and Sales Agreement with Hillside, LP

25 October 1993 Initial Change in Effective Control (CEC) application filed and subsequently amended by Hillside, LP on 27 October 1993 to purchase the JHARI

27 October 1993 Superior Court issues preliminary court order prohibiting sale and prohibiting DOH from revoking license pending resolution of residents' objection to facility sale.

27 October 1993 Last remaining patient leaves JHARI

28 October 1993 DOH responds to JHARI variance letter request stating that their request for variance is pending Court action

28 October 1993 DOH sends letter to applicant stating that initiation of CEC review is pending Court action

19 January 1994 Judge Israel vacates prior preliminary Court ruling and on 27 January 1994 issues Court Order denying plaintiffs objection to sale

4 February 1994 FInal review of CEC application commenced

8 February 1994 DOH grants variance to JHARI to extend viability of license

16 February 1994 Hillside requests expeditious review for CON for facility renovations

22 February 1994 HSC recommends expeditious review for a CON renovation project of approximately $2 million that would be filed in March 1994 and that the facility would reopen in July 1994. On 25 February 1994 DOH grants expeditious review for CON renovations

11 March 1994 DOH corresponded to both the US Attorney General and RI Attorney General's Office regarding Mr. Giordano's status with federal and state Medicare, Medicaid and HUD.
16 March 1994 US Attorney General responds in writing that it had no knowledge of any criminal convictions and that Mr. Giordano was not subject to any current investigation.
21 March 1994 RI Attorney General's Office written response did not identify any specific concerns.
11 April 1994 Division of Facilities Regulations advised that the 2 facilities (Coventry and Mt. St. Francis) owned by the proposed owners are in substantial compliance.
19 April 1994 HSC subcommittee recommended CEC approval subject to $1,000,000 (20%) equity and recapture of depreciation.
26 April 1994 HSC modified subcommittee recommendation and lowers equity requirement to $50,000 (1%) and deleted recapture of depreciation requirement as not within DOH's jurisdiction.
28 April 1994 Director of Health modified HSC recommendation and approved CEC application requiring $507,000 (10%) in cash equity.
2 June 1994 Hillside files suit with Superior Court challenging the DOH equity requirement

Phase II CEC Appeal and Rrevised Timeline
7 November 1994 Hillside sends letter to DOH outlining a new timetable with the closing now expected to take place in September 1995 and the facility opening in early 1996
21 November 1994 JHARI requests extension license variance (February 1994)
21 November 1994 DOH sends letter to JHARI regarding variance and recapture of depreciation
23 November 1994 Applicant requests extension license variance
7 December 1994 DOH requests advice from DHS regarding impact of extension of variance on recapture of depreciation
13 December 1994 DHS responds to DOH letter stating noting timeframe concerns and that in the absence of a legally binding agreement the State of Rhode Island could lose approximately $696,000 in recapture funds from the Jewish Home at the time of the sale."
15 December 1994 DOH sends letter to JHARI regarding concerns of variance and recapture of depreciation
10 January 1995 DHS responds to DOH with a signed agreement with JHARI regarding recapture of depreciation
17 January 1995 Hillside dismisses Superior Court suit on equity requirement.
23 January 1995 DOH grants extension of variances to JHARI and Hillside with specific timeframes .

Phase III CON Review and Change in Operator Review
22 February 1995 Hillside files CON for renovations at $6.2 million capital cost
1 March 1995 DOH sends deficiency letter to applicant re CON
4 May 1995 Applicant resubmits CON application that indicates Hillside, LLC as an operator
6 June 1995 DOH states that Hillside, LLC must file CEC for change in operator
15 August 1995 Hillside resubmits CON for renovations and files CEC for Hillside, LLC for a change in operator
September/December 1995 Deficiencies outstanding over CEC and CON
27 December 1995 Deficiency issues resolved; applications ready for review.
4 January 1996 DOH sends applicant letter indicating the CEC and CON reviews will commence on 9 January 1996
9 January 1996 CON and CEC applications are heard before HSC subcommittee; Hillside states that the equity for the CON renovation project will be 20% and will be in the form of cash
February/27 June 1996 Numerous and voluminous correspondence exchanged primarily

between DOH and Hillside but also including, DHS, DEPCO and the Attorney General's Office covering issues of equity, working capital, Annex costs, viability and home office expenses.
27 June 1996 HSC subcommittee recommended approval of CON and CEC
16 July 1996 HSC recommended approval of CON and CEC
22 July 1996 Hillside CON application for renovations denied by DOH.
23 July 1996 DOH approved Hillside Health Center, LLC for CEC
14 August 1996 Hillside requested reconsideration appeal
6 September 1996 DOH denied Hillside reconsideration request
17 September 1996 Hillside requested Administrative Review of CON denial
24 April 1997 Administrative Review upheld the DOH denial of CON renovations
May 1997 Hillside appeals CON denial to Superior Court

Phase IV Revised Scope, Reduction in Beds, Revised Timeline
1 May 1997 Hillside proposes a scaled down alternative of a 150-bed nursing facility underneath CON review threshold ($2 million) for renovations.
9 December 1997 DOH and Hillside enter into a Consent Order that limits Hillside to a l50-bed nursing facility and renovation costs not to exceed CON review threshold
10 December 1997 DOH amends variance issued to Hillside and JHARI that incorporates Consent Order
Jan 1998-August 1998 Numerous correspondence among/between Hillside, JHARI and DOH requiring documentation to compliance of all matters related to Consent Order, HUD and CEC approvals.
August 1998 DOH signed off on Hillside.

CMS – Scope & Severity

	PoC	PoC	PoC
	J	**K**	**L**
Immediate Jeopardy to Resident Health or Safety	Required: Cat. 3 Optional: Cat. 1 Optional: Cat 2	Required: Cat. 3 Optional: Cat. 1 Optional: Cat 2	Required: Cat. 3 Optional: Cat. 2 Optional: Cat 1
	G	**H**	**I**
Actual Harm that is not Immediate Jeopardy	Required* Cat. 2 Optional: Cat. 1	Required* Cat. 2 Optional: Cat. 1	Required* Cat. 2 Optional: Cat. 1 Optional: Temporary Mgmt.
	D	**E**	**F**
No Actual Harm with Potential for More than Minimal Harm that is not Immediate Jeopardy	Required* Cat. 1 Optional: Cat. 2	Required* Cat. 1 Optional: Cat. 2	Required* Cat. 2 Optional: Cat. 1
	Substantial compliance		
	A	**B**	**C**
No Actual Harm with Potential for Minimal Harm	No Remedies Commitment to Correct Not on CMS-2567L	**PoC**	**PoC**
	Isolated	**Pattern**	**Widespread**

Substandard quality of care (SQC): Any deficiency in §483.13 Resident Behavior and Facility Practices, §483.15 Quality of Life, or in §483.25, Quality of Care that constitutes: immediate jeopardy to resident health or safety; or, a pattern of or widespread actual harm that is not immediate jeopardy; or, a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Substantial compliance

Remedy Categories

Category 1 (Cat. 1)	**Category 2 (Cat. 2)**	**Category 3 (Cat. 3)**
Directed Plan of Correction State Monitor; and/or Directed In-service Training	Denial of Payment for New Admissions Denial of Payment for All Individuals, Imposed by CMS; and/or Civil Money Penalties: $50 - $3,000 per day or per instance	Temporary Management Termination **Optional:** Civil Money Penalties: $3,050 - $10,000 per day

DENIAL OF PAYMENT FOR NEW ADMISSIONS must be imposed when a facility is not in substantial compliance within three months after being found out of compliance.

DENIAL OF PAYMENT AND STATE MONITORING must be imposed when a facility has been found to have provided substandard quality of care (SQC) on three consecutive standards surveys.

****Required only when decision is made to impose alternate remedies instead of or in addition to termination.***
Note: Termination may be imposed by the State or CMS at any time when appropriate.